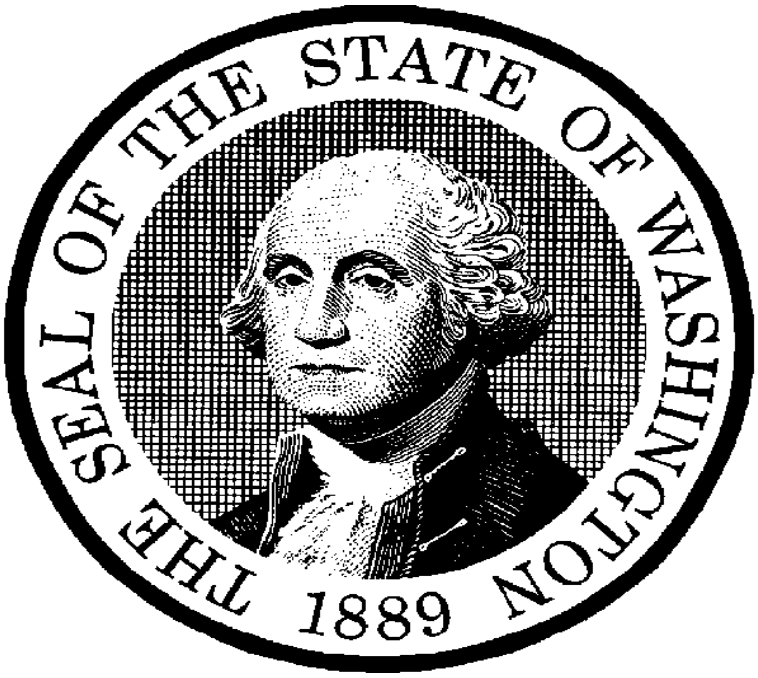
Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration



General Information Booklet

September 2000

About this publication

This booklet should be used **in addition to** the billing instructions for your specific scope of care. **This publication supersedes the previous General Information Booklet, dated March 1995 and the following issuances:**

Numbered Memoranda:
95-88, 95-95, 95-107, 96-24, 96-69, 97-68, 98-06, 98-31, 98-37, 98-41, 98-51, 99-62, 99-63, 00-12

Medical News Bulletins:
12/95 #1, 12/95 #2, 1/96 #1, 2/96 #1

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
September 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Section K: Rebillings and Adjustments

Section L: DSHS Community Services Offices (CSOs)

Section M: DSHS Home and Community Services (HCS)

Section N: Rules Checklist

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

Where do I call for information on becoming a DSHS provider?

Provider Enrollment Unit
(800) 562-6188
Select Option 1 -or-
(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I call for prior authorization?

Acute Physical Medicine and Rehabilitation (PM&R) **1-800-634-1398**

Durable Medical Equipment (DME) and Prosthetics & Orthotics.
1-800-292-8064

Pharmaceutical/Drugs
1-800-848-2842

How can I be notified when MAA's Washington Administrative Codes change?

If you are interested in receiving notices about rule changes (WAC) fill out the Rule Checklist located in Section N and send it to the address listed on the back.

This will place you on the mailing list for the rules you are interested in receiving.

What is MAA's web site address?

http://maa.dshs.wa.gov

Who do I contact if I have questions on…

Payments, denials, general questions regarding claims processing, Healthy Options?

Provider Relations Unit (PRU)
1-800-562-6188

Private insurance or third party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136

Where do I get copies of billing instructions?

Check out our web site
http://maa.dshs.wa.gov,
go to the Billing Instructions link.

-or-

Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562
1-800-562-6188

Important Toll Free Numbers

Acute Physical Medicine & Rehabilitation (PM&R) Authorization **(Providers Only)**	1-800-634-1398
Ambulance Transportation/Hospice Authorization	1-800-624-4793
Disability Insurance	1-800-562-6074
Durable Medical Equipment (DME)/Prosthetics & Orthotics Authorization **(Providers Only)**	1-800-292-8064
Fraud Hotline	1-800-562-6906
Medical Assistance Customer Service Center (MACSC) **(Clients Only)** Access Issues Broker Transportation Client Complaints Healthy Options Enrollment, Disenrollment, Exemptions	1-800-562-3022
Medical Eligibility Determination Services (MEDS) Children's Medical, Healthy Options and Basic Health Plus	1-800-204-6429
Pharmacy Authorization **(Providers Only)**	1-800-848-2842
Provider Inquiry Hotline **(Providers Only)**	1-800-562-6188
Telecommunications Device For The Deaf (TDD)	1-800-848-5429
Third-Party Resource Hotline	1-800-562-6136

Program Support Field Representatives

(360) 725-1022
(360) 725-1023
(360) 725-1024
(360) 725-1027
(360) 725-1020

MAA Addresses

Claims for Payment

Drug Claims, Medicare Crossovers, ITA Claims, Other Claims Not Listed Below	Division of Program Support PO Box **9245** Olympia, WA 98507-9245
Inpatient Hospital Claims, DRG Hospital Claims	Division of Program Support PO Box **9246** Olympia, WA 98507-9246
Medical Vendor Claims	Division of Program Support PO Box **9247** Olympia, WA 98507-9247
Physician Claims	Division of Program Support PO Box **9248** Olympia, WA 98507-9248
Outpatient Hospital Claims	Division of Program Support PO Box **9249** Olympia, WA 98507-9249
Nursing Home Turnaround Documents (TAD)	Division of Program Support PO Box **9250** Olympia, WA 98507-9250
Dental Claims	Division of Program Support PO Box **9253** Olympia, WA 98507-9253
Magnetic Tape Claims/ Floppy Disk Claims	Division of Program Support Claims Control PO Box **45560** Olympia, WA 98504-5560
Electronic Billing Information	Electronic Billing PO Box **45511** Olympia, WA 98504-5511 (360) 725-1267

Claim Inquiries/Provider Correspondence

Provider Correspondence
Requests for Billing Instructions/
Numbered Memorandum
Address Changes/Corrections
Provider Enrollment

Division of Program Support
Provider Relations Unit
PO Box **45562**
Olympia, WA 98504-5562

Third-Party Liability Inquiries

Third-Party Liability
Health Insurance Inquiries

Division of Client Support
Coordination of Benefits – Health Unit
PO Box **45565**
Olympia, WA 98504-5565

Third-Party Liability
Casualty Insurance Inquiries

Division of Client Support
Coordination of Benefits – Casualty Unit
PO Box **45561**
Olympia WA 98504-5561

Utilization Review/Authorization Requests

Durable Medical Equipment,
Prosthetics, Orthotics, Dental,
& Orthodontics

Division of Health Services Quality Support
Quality Utilization Section
PO Box **45506**
Olympia, WA 98504-5506
Fax: (360) 586-5299

Pharmacy,
Acute Physical Medicine &
Rehabilitation (Acute PM&R)

Division of Health Services Quality Support
Quality Fee-For-Service Section
PO Box **45506**
Olympia, WA 98504-5506
Fax: (360) 586-2262

Billing Addresses for Healthy Options, Managed Care Plans - Year 2000

See page D.5 for plan abbreviations.

Aetna US Healthcare of Washington
PO Box 91023
Seattle, WA 98111-9123

Clark United Providers
16701 SE McGillivray Ste. #201
Vancouver, WA 98663
(Changing to Columbia United Provider on 1/1/01)

Community Health Plan of Washington
Information Systems
1100 Olive Way, Ste 200
Seattle, WA 98101

*(Also covers **CHIP** clients.)*

Group Health Cooperative (West)
Claims Administration
PO Box 34585
Seattle, WA 98124-1750

Group Health Cooperative (East)
Claims Administration
PO Box 200
Spokane, WA 99210

Kaiser Permanente
Claims and Referrals Department
500 NE Multnomah St.
Portland, OR 97232

Molina Healthcare of Washington, Inc.
(formerly QualMed Health Plan)
Claims Department
PO Box 35500
Long Beach, CA 90832

Northwest Washington Medical Bureau
333 East Gilkey
Burlington, WA 98233-2823

*(Also covers **CHIP** clients.)*

Premera Blue Cross
Healthy Options and Basic Health Plan
PO Box 12890
Seattle, WA 98111-4890

Regence Blue Shield
PO Box 21267
Seattle, WA 98111-3267

Regence Blue Shield of Idaho
(Asotin/Garfield Co. providers)
PO Box 1106
Lewiston, ID 83501-1106

List of MAA Billing Instructions

Access to Baby & Child Dentistry
Adult Day Health Services
Ambulatory Surgery Center
Births in Birthing Centers
(formerly Licensed Midwives)
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Chiropractic Services
Chronic Pain Management
Dental/Orthodontic Program
Direct Entry
Electronic Billing Manual
Family Planning
Federally Qualified Health Centers
First Steps Child Care Manual
Fluoride Varnish Applications
General Information Booklet
Ground and Air Ambulance Medical Transportation
Healthy Kids/EPSDT
Healthy Options Licensed Health Carriers
Hearing Aids Program
HIV/AIDS Case Management
Home Health Services
Hospice
Hospital-Based Inpatient Detoxification
Hospital Inpatient
Hospital Outpatient
Indian Health Services
Infusion Therapy
Interpreter Services
Involuntary Treatment Act (I.T.A.)
Kidney Centers
Maternity Case Management
Maternity Support Services
Medical Nutrition *(formerly Infusion/Enteral/Parenteral)*
Medicare Part B/Medicaid Crossovers
Neurodevelopmental Centers
Nondurable Medical Equipment & Supplies
Nutritional Services for Children
Nurse Delegation
Nursing Facilities
Occupational Therapy Program
Oxygen & Respiratory Therapy
Physical Medicine & Rehabilitation (Acute)
Physical Therapy Program
Physician-Related Services (RBRVS)
Prenatal Genetic Counseling
Prescription Drug Program
Private Duty Nursing
Prosthetic and Orthotic Devices
Psychologist
Registered Nurse First Assistant (For Cesarean Sections)
Rural Health Clinics
School Medical Services
Speech/Audiology Program
Vision Care
Wheelchairs, Durable Medical Equipment & Supplies

For more information on MAA billing instructions, call 1-800-562-6188.

As these billing instructions are updated, they will be loaded onto our web site: http://maa.dshs.wa.gov

Definitions

The section defines terms and acronyms used in this booklet.

Assignment - A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Assignment of Rights - The assignment of a Medical Assistance client's rights to medical insurance and support to the Department of Social and Health Services (DSHS). This provides the Medical Assistance Administration (MAA) the legal basis to redirect and recover these benefits in conformance with federal third-party requirements.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A nine-digit number, assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Authorization Requirement - In order to obtain authorization for some services and equipment, you must provide proof of medical necessity. Each request must include a complete, detailed description of the diagnosis and/or any disabling conditions, justifying the need for the equipment or the level of service being requested.

Basic Health Plus – A program jointly managed by the Health Care Authority and the Medical Assistance Administration. Parents can obtain coverage under BH while their children can be enrolled in the BH Plus program. BH Plus offers children the expanded benefits available in the Healthy Options/MAA benefit package. This allows BH families to remain together in the same managed health care plan. *(Not to be confused with Basic Health which is sponsored by the Health Care Authority, not MAA.)*

Benefit Period - The time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a `spell of illness' for Medicare payments.

Carrier - A private organization (usually an insurance company) that has a contract with the federal government to 1) review, approve and/or deny claims, and 2) process the paperwork for Medicare Part B (medical insurance). For Medicare Part A, these companies are called *intermediaries*.

Categorically Needy (CNP) - CNP programs are the federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for:

- CNP only;
- Cash benefits under the SSI (Supplemental Security Income);
- TANF (Temporary Assistance for Needy Families);
- General Assistance – X (special); and
- General Assistance (children's).

CNP includes full scope coverage for pregnant women and children.

CNP Children's Program - Low-income children are usually eligible for the CNP children's program. This program has two categories, newborns, and children under the age of 19.

Children's Health Insurance Program (CHIP) - A federal/state program that covers children under 19 years of age in families whose income is too high for Medicaid, but is from 200 to 250% of the Federal Poverty Level. (*Not to be confused with the Children's Health Program.)*

Children's Health Program - The Children's Health Program is the state-funded program for children under age 18 who are not eligible for Medicaid. (*Not to be confused with the Children's Health Insurance Program – CHIP.)*

Client - An applicant for, or recipient of, DSHS medical care programs.

Client Support, Division of (DCS) – The division within MAA responsible for:

- Client enrollments, exemptions and disenrollments in managed care plans;
- Coordination of Medicare and private insurance benefits;
- Transportation and interpreter services;
- Operation of a customer service hot-line; and
- Administration of a centralized children's eligibility section and CHIP, eligibility policy, marketing and outreach.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Coinsurance - The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is 20% of reasonable charges.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Current Dental Terminology (CDT) – A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. The Council on Dental Benefit Programs of the American Dental Association (ADA) publishes CDT.

Current Procedural Terminology (CPT) – A description of medical procedures available from the American Medical Association of Chicago, Illinois.

Deductible-Medicare – An initial specified amount that is the responsibility of the client.

- **Part A of Medicare-Inpatient Hospital Deductible -** An initial amount of the medical care cost in each benefit period which Medicare does not pay.

- **Part B of Medicare-Physician Deductible** - An initial amount of Medicare Part B covered expenses in each calendar year that Medicare does not pay. (WAC 388-500-0005)

Department - The state Department of Social and Health Services [DSHS]. (WAC 388-500-0005)

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - Also known as the "Healthy Kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Expedited Prior Authorization (EPA) – A process designed by MAA to eliminate the need for written prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies the criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

Fee-for-Service – The general payment method MAA uses to reimburse for covered medical services provided to medical assistance clients when these services are not covered under MAA's managed care program.

Health Services Quality Support, Division of (DHSQS) – The division within MAA responsible for promoting and improving the quality of health care consistent with community practice standards and including access, cost effectiveness, coordination and accountability to produce positive client outcomes.

Healthy Kids -- See EPSDT.

Healthy Kids Now - The umbrella name given to all children's medical programs in Washington. These programs are marketed using this term.

Healthy Options - The name of the Washington State, Medical Assistance Administration's managed care program.

Home and Community Services (HCS) Offices – An office of the department that administers programs for Long Term Care and Community Based Services at the community level.

Integrated Provider Network Database (IPND) – A database developed in partnership by the Health Care Authority and DSHS-MAA to provide verified and integrated provider network information for all health plans serving Basic Health, CHIP, Healthy Options, and PEBB via the Internet and an internal user interface.

Intermediary - A private organization (usually an insurance company) that has been designated by the Health Care Financing Administration (HCFA) to process claims and make payments to hospitals for Medicare Part A (hospital insurance). For Medicare Part B, these organizations are called *carriers*.

Julian Date – Consecutively numbered day of the year (e.g., January 1 is 001, January 31 is 031, February 1 is 032, etc.).

Limitation Extension – Prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in MAA's billing instructions.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medical Care Services (MCS) - MCS is the state-administered medical program that provides limited medical benefits to persons eligible for ADATSA and General Assistance-Unemployable (GA-U).

Medical Eligibility Determination Services (MEDS) – A section within the Division of Client Support, Medical Assistance Administration that determines eligibility statewide for children and interfaces with the Health Care Authority in determining eligibility for Basic Health Plus and Basic Health maternity benefits.

Medically Indigent (MIP) - The state-administered Medically Indigent (MIP) program provides very limited medical coverage for persons who:

- Have an emergency medical condition requiring hospital services; and
- Are not eligible for cash benefits or for any other medical program.

Medically Necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medically Needy (MNP) – The Medicaid program for aged, blind, or disabled persons, pregnant women, children and refugees with income and/or resources above CNP limits. It provides less medical coverage than CNP.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Case Management (PCCM) The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services (WAC 388-538-050)

Primary Care Provider (PCP) – A person licensed or certified under Title 18 RCW including, but not limited to, a physician and advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care. (WAC 388-538-050)

Prior Authorization – Written MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. *Expedited prior authorization and limitation extensions are forms of prior authorization.*

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Pregnant Women's Program - The CN medical program for low-income pregnant women that has income limits based on 185 percent of the Federal Poverty Level (FPL) and no resource limits.

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

State Family Assistance (SFA) - SFA is the state-funded cash and medical program for legal immigrant families who do not meet the eligibility requirements for the federal programs. It provides the same scope of medical coverage as CNP.

Supplemental Security Income (SSI) – A Federal cash program for aged, blind, or disabled persons. Clients receive both SSI cash benefits and Categorically Needy (CN) medical. Clients who are aged, blind, or disabled can receive CN or MN medical only. The federal Social Security Administration (SSA) administers the SSI program.

TAKE CHARGE – The Medicaid Section 1115 Demonstration Waiver that provides family planning to men and women with income at or below 200% of the Federal Poverty Level.

Temporary Assistance to Needy Families (TANF) - Program offering cash, medical, and other benefits to families in need.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005

Title XXI - The portion of the federal Social Security Act that authorizes grants to states for the Children's Health Insurance Program (CHIP). (WAC 388-538-0006)

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Work First - Washington State's response to federal welfare legislation replacing the former AFDC program. The federal government currently sends block grants to states for TANF.

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Commonly Used Acronyms

Acronym	Description
AAA	Area Agency on Aging
AASA	Aging & Adult Services Administration (DSHS)
ACES	Automated Client Eligibility Systems
ADA	American Dental Association
ADA	American Disabilities Act
ADATSA	Alcohol and Drug Addiction Treatment and Support Act
AG	Attorney General
AIDS	Acquired Immune Deficiency Syndrome
ALF	Alternative Living Facility
ALJ	Administrative Law Judge
AMA	American Medical Association
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgery Center
BAU	Base Anesthesia Unit
BH Plus	Basic Health Plus
BR	By Report
CAP	Community Alternative Program
CASA	Community AIDS Service Alternative Program
CCF	Congregate Care Facility
CDC	Center for Disease Control
CDT	Current Dental Terminology
CF	Conversion Factor
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health & Medical Program of the Uniformed Services
CHC	Community Health Clinic
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Act
CMHC	Community Mental Health Center
CNP	Categorically Needy Program
COPES	Community Options Program Entry Services
CPAS	Claims Processing Assessment System
CPS	Child Protective Services
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSO	Community Services Office
CUP	Chemically-Using Pregnant Woman
DASA	Division of Alcohol and Substance Abuse (DSHS)
DCFS	Division of Child and Family Services (DSHS – Children's Admin)
DCS	Division of Child Support (DSHS – ESA)
DCS	Division of Client Support (DSHS - MAA)
DDD	Division of Developmental Disabilities (DSHS)

DDDS.....Division of Disability Determination Services (DSHS - MAA)
DEERS.....Defense Enrollment Eligibility Reporting System
DHHS.....Department of Health and Human Service (Federal)
DHSQS .....Division of Health Services Quality Support (DSHS-MAA)
DME.....Durable Medical Equipment
DMERC .....Durable Medical Equipment Regional Carrier
DOB .....Date of Birth
DOD.....Date of Death
DOH.....Department of Health (state)
DOS.....Division of Operational Support (DSHS – MAA)
DPS .....Division of Program Support (DSHS-MAA)
DRG .....Diagnosis Related Grouping
DSHS .....Department of Social and Health Services (state)
EAC.....Estimated Acquisition Cost
ECF .....Extended Care Facility
EMC.....Electronic Media Claims
EOB.....Explanation of Benefits
EOMB .....Explanation of Medicare Benefits
EPA.....Expedited Prior Authorization
EPSDT .....Early and Periodic Screening, Diagnosis, and Treatment
ESA.....Economic Services Administration (DSHS)
ESRD .....End Stage Renal Disease
FECA .....Federal Employee Compensation Act
FFP.....Federal Financial Participation
FICA.....Federal Insurance Contributions Act – Social Security
FQHC.....Federally Qualified Health Center
FSS.....Financial Services Specialist
FSU .....Field Services Unit (DSHS – MAA – DPS)
GA-H.....General Assistance - Children
GA.....General Administration
GA-W.....General Assistance - ADATSA
GA-X.....General Assistance – Unemployable w/Expedited Categorically Needy
HCA .....Health Care Authority (state)
HCFA.....Health Care Financing Administration (federal)
HCPCS.....HCFA's Common Procedure Coding System
HCS.....Home and Community Services (DSHS – AASA)
HIC.....Health Insurance Code
HIV.....Human Immunodeficiency Virus
HMO .....Health Maintenance Organization
ICD-9 .....Internal Classification of Diseases – 9th Revision
ICF .....Intermediate Care Facility
ICN.....Internal Control Number
IDG.....Interdisciplinary Group
IHS .....Indian Health Services
IMD.....Institution for the Mentally Diseased
IMR.....Institute for Mentally Retarded
ISSD.....Information Systems Services Division

ITA	Involuntary Treatment Act
JRA	Juvenile Rehabilitation Administration (DSHS)
LAN	Local Area Network
LCP	Limited Casualty Program
LCP-MIP	Limited Casualty Program – Medical Indigent Program
LCP-MNP	Limited Casualty Program – Medically Needy Program
LEP	Limited English Proficiency
LIST	Language Interpreter Services and Translations (DSHS)
LOS	Length of Stay
LTC	Long Term Care
MAA	Medical Assistance Administration (DSHS)
MAID	Medical Assistance IDentification (card)
MCM	Maternity Case Management
MCS	Medical Care Services
MEDS	Medical Eligibility Determination Section (MAA-DCS)
MEV	Medical Eligibility Verification
MHD	Mental Health Division (DSHS)
MI(P)	Medically Indigent Program
MMIS	Medicaid Management Information System
MNP	Medically Needy Program
MOA	Memorandum of Agreement
MSA	Metropolitan Statistical Area
NABP	National Association Board of Pharmacy
NH	Nursing Home
OBRA	Omnibus Budget Reconciliation Act
OIS	Office of Information Services
OT	Occupational Therapy
PA	Prior Authorization
PCCM	Primary Care Case Manager/Management
PDDD	Procedure, Diagnosis, Drug, and DRG File
PEU	Provider Enrollment Unit (DSHS – MAA – DPS)
PCP	Primary Care Provider
PIC	Patient Identification Code
PM&R	Physical Medicine & Rehabilitation (Acute)
POC	Plan of Care
POS	Place of Service
PRR	Patient Requiring Regulation
PRU	Provider Relations Unit (DSHS – MAA - DPS)
PT	Physical Therapy
QMB	Qualified Medicare Beneficiary
RA	Regional Administrator
RA	Remittance Advice
RBRVS	Resource-Based Relative Value Scale
RCW	Revised Code of Washington
RHC	Rural Health Clinic
RVS	Relative Value System
RVU	Relative Value Units

RX	Treatment/Prescription
SCA	Selective Contracting Area
SCAN	State Controlled Area Network
SMIB	Supplementary Medical Insurance Benefit – Medicare Part B
SNF	Skilled Nursing Facility
TAD	Turnaround Document
TANF	Temporary Assistance to Needy Families
TDD	Telecommunications Device for the Deaf
TISS	Transportation & Interpreter Services Section
TOS	Type of Service
TPL	Third Party Liability
WAC	Washington Administrative Code

About Medical Assistance

What is Medical Assistance?

Medical assistance is the common phrase used to describe all programs available to low-income Washington State residents through the Medical Assistance Administration (MAA).

The following is a list of these programs:

- **Medicaid (federal/state funded)**
  - ✓ Categorically Needy Program (CNP); and
  - ✓ Medically Needy Program (MNP).
- **Medical Care Programs (state-administered)**
  - ✓ Family Planning Only Program;
  - ✓ General Assistance Unemployable (GA-U);
  - ✓ Alcohol and Drug Addiction Treatment and Support Act (ADATSA); and
- **Children's Health Insurance Program (CHIP) (federal/state funded)**
- **Medicare Cost Sharing Program**
  - ✓ Qualified Medicare Beneficiary (QMB);
  - ✓ Special Low Income Medicare Beneficiary (SLMB);
  - ✓ Expanded Special Low Income Medicare Beneficiary (ESLMB);
  - ✓ Qualified Disabled Working Individuals (QDWI); and
  - ✓ Qualified Individuals (QI).
- **TAKE CHARGE Family Planning Program (federal/state funded) - referred to as TAKE CHARGE**

What is the Medical Assistance Administration's mission and goals?

Mission:

The Medical Assistance Administration's (MAA) mission is to maximize opportunities for low-income people to obtain quality health services and make fair, accurate and timely disability determinations.

Goals:

- Provide quality and timely disability determinations while containing costs in the disability determination process;
- Enhance the customer-focused orientation within MAA, using continuous quality improvement principles;
- Improve the quality of access to, and satisfaction with, health care services received by MAA clients;
- Improve the performance of operational systems essential to supporting client access to quality health services; and
- Promote an open, inclusive and supportive work environment that values our employees and encourages them to take risks and share accountability.

Procedure Codes

The following types of codes are used with MAA's billing instructions:

- American Dental Association Current Dental Terminology (CDT) codes;
- ICD-9-CM codes (limited to hospitals).
- Level II Health Care Financing Administration's Common Procedure Coding System (HCPCS);
- National Drug Code (NDC);
- Physicians' Current Procedural Terminology (CPT™) codes;
- State-unique codes; and
- UB-92 revenue codes.

MAA uses the descriptions and guidelines from the most current CPT, HCPCS, CDT, and ICD-9-CM manual for all MAA-covered services, unless otherwise specified in MAA's billing instructions.

Note: MAA adopts Medicare's guidelines and policies whenever possible.

Diagnosis Codes

MAA uses ICD-9-CM codes for physician-related services. (See MAA's Physician-Related Services Billing Instructions (known as RBRVS) for specific coverage information.)

By Report (BR)

MAA may require a special report for certain services provided to MAA clients to determine whether the procedure is necessary. These services are identified by a **BR** (By Report) in the procedure code listings in certain MAA fee schedules. This special report must include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary for the procedure or service. MAA may request additional information from the provider.

Border Areas **(WAC 388-501-175)**

(Considered within Washington State when contracted with MAA)

Medical care will be provided to eligible clients in recognized bordering cities on the same basis as in-state care. The *only* Washington State recognized bordering cities are:

In Idaho:	Moscow, Sandpoint, Priest River, Lewiston, and Coeur d'Alene
In Oregon:	Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria

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Provider Requirements

The Medical Assistance Administration (MAA) reimburses enrolled providers for furnishing covered medical services, equipment, and supplies to eligible clients.

Eligibility for enrollment [Refer to WAC 388-502-0010]

To be eligible for enrollment, a provider must:

- Be licensed, certified, accredited, or registered according to Washington state laws and regulations; and
- Meet the conditions in this section and in specific program billing instructions regulating the specific type of provider, program, and/or service.

Enrollment

To enroll, an eligible provider must sign a core provider agreement or a contract with DSHS and receive a unique provider number. **The following eligible providers may request enrollment:**

ARNPs
Anesthesiologists
Audiologists
Chiropractors
Dentists
Dental hygienists
Denturists
Dietitians or Nutritionists
Maternity case managers
Midwives
Occupational therapists
Ophthalmologists
Opticians
Optometrists
Orthodontists
Osteopaths
Podiatric physicians
Physicians
Physical therapists
Psychiatrists
Psychologists
RN Delegators
RN First Assistants
Respiratory therapists
Speech/language pathologists
Radiologists
Radiology technicians (technical only)

Adult day health centers
Ambulance services (ground/air)
Ambulatory surgery centers (Medicare-certified)
Birthing centers (licensed by DOH)
Blood banks
Chemical dependency treatment facilities certified by DASA and contracted through either a county or DASA
Centers for detox (certified by DASA)
CASA agencies
Community mental health centers
EPSDT clinics
Family planning clinics
FQHCs (designated by HCFA)
Genetic counseling agencies
Health departments
HIV/AIDS case management
Home care agencies
Home health agencies
Hospice agencies
Hospitals
Indian Health Service Tribal, or urban Indian clinics
Inpatient psychiatric facilities

Intermediate care facilities for mentally retarded (ICF-MR)
Kidney centers
Laboratories (CLIA certified)
Maternity support services agency
Neuromuscular/developmental ctrs
Nursing facilities (approved by DSHS AASA)
Pharmacies
Private duty nursing agencies
Rural health clinics (Medicare-certified)
Tribal mental health services (contracted through MHD)
Washington state school districts and educational service districts

Suppliers of:
Durable and nondurable medical equipment and supplies, Infusion therapy equipment and supplies, Prosthetics/orthotics, Hearing aids, Oxygen equipment and supplies.

Contractors of:
Transportation brokers; Interpreter services agencies; and
Eyeglass and contact lens providers

Nothing in chapter 388-502 WAC precludes DSHS from entering into other forms of written agreements to provide services to eligible clients.

MAA does not enroll licensed or unlicensed practitioners not specifically addressed in the list on the previous page, including, but not limited to:

- Acupuncturists;
- Counselors;
- Sanipractors;
- Naturopaths;
- Homeopaths;
- Herbalists;
- Massage therapists;
- Social workers; or
- Christian Science practitioners or theological healers

General Provider Requirements **[Refer to WAC 388-502-0020]**

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, <u>for six years from the date of service</u> or longer if required specifically by federal or state law or regulation.

- Bill DSHS according to DSHS rules and billing instructions;
- Include and sign the following statement with each bill submitted to DSHS for reimbursement:

  "I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the state of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payee; and that all good furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, sex, religion, national origin, marital status, or the presence of any sensory, mental or physical handicap.

- Accept the payment from DSHS as payment in full;
- Follow the requirements in WAC 388-502-0160 and 388-538-095 about billing clients;
- Fully disclose ownership and control information requested by the department;
- Not pay a third party biller a percentage of amounts collected, or discount client accounts to a third party biller;
- Provide all services without discriminating on the grounds of race, creed, color, age, sex, religion, national origin, marital status, or the presence of any sensory, mental, or physical handicap; and
- Provide all services according to federal and state laws and rules and billing instructions issued by the department.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern DSHS's programs.

Denying, Suspending, and Terminating Enrollment

[Refer to WAC 388-502-0030]

- DSHS terminates enrollment or does not enroll or re-enroll a provider if, in DSHS's judgement, it may be a danger to the health or safety of clients.

- Except as noted in the next bullet, DSHS does not enroll or reenroll a provider to whom any of the following apply:

  - ✓ Has a restricted professional license;
  - ✓ Has been terminated, excluded, or suspended from Medicare/Medicaid; or
  - ✓ Has been terminated by the department for quality of care issues or inappropriate billing practices.

- DSHS may choose to enroll or re-enroll a provider who meets the conditions in the bullet above, if **all** of the following apply:

  - ✓ The department determines the provider is not likely to repeat the violation that led to the restriction or sanction;
  - ✓ The provider has not been convicted of other offenses related to the delivery of professional or other medical services in addition to those considered in the previous sanction; and
  - ✓ If the United States Department of Health and Human Services (DHHS) or Medicare suspended the provider from Medicare, DHHS or Medicare notifies the department that the provider may be reinstated.

- DSHS gives 30 days written notice before suspending or terminating a provider's enrollment. However, the department suspends or terminates enrollment immediately if any one of the following situations apply:

  - ✓ The provider is convicted of a criminal offense related to participation in the Medicare/Medicaid program;
  - ✓ The provider's license, certification, accreditation, or registration is suspended or revoked;
  - ✓ Federal funding is revoked;
  - ✓ By investigation, the department documents a violation of law or contract;
  - ✓ The MAA Medical Director or designee determines the quality of care provided endangers the health and safety of one or more clients; or
  - ✓ DSHS determines the provider has intentionally used inappropriate billing practices.

- DSHS terminates a provider's number if the provider:

  - ✓ Does not disclose ownership or control information;
  - ✓ Does not submit a claim to the department for 24 consecutive months;
  - ✓ Has an incorrect address on file with DSHS;
  - ✓ Requests a new provider number (e.g., change in tax identification number or ownership); or
  - ✓ Voluntarily withdraws from participation in the Medical Assistance program.

Note:	Nothing in chapter 388-502 WAC obligates DSHS to enroll all eligible providers who request enrollment.

General Conditions of Payment **[Refer to WAC 388-502-0100]**

- DSHS reimburses for medical services furnished to an eligible client when all of the following apply:

  - ✓ The service is within the scope of care of the client's medical assistance program;
  - ✓ The service is medically necessary;
  - ✓ The service is properly authorized;
  - ✓ The provider bills within the timeframe set in WAC 388-502-0150 (See Billing Section on page H.1);
  - ✓ The provider bills according to DSHS rules and billing instructions; and
  - ✓ Provider follows third-party payment procedures.

- DSHS is the payer of last resort, unless the other payer is:

  - ✓ An Indian Health Service; or
  - ✓ Crime Victims, through the Department of Labor and Industries; or
  - ✓ A school district for health services provided under the Individuals with Disabilities Education Act.

- The provider must accept Medicare assignment for claims involving clients eligible for both Medicare and Medical Assistance before MAA makes any payment.

- The provider is responsible for verifying whether a client has Medical Assistance coverage for the dates of service.

- DSHS may reimburse a provider for services provided to a person if it is later determined that the person was ineligible at the time of service if:

  - ✓ DSHS considered the person eligible at the time of service;
  - ✓ The service was not otherwise paid for; and
  - ✓ The provider submits a request for payment to DSHS.

- DSHS does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.

- Information about medical care for jail inmates is found in RCW 70.48.130.

- DSHS pays for medically necessary services based on usual and customary charges or the maximum allowable rate established by the department, whichever is lower.

DSHS Payment Integrity Program (PIP)

(formerly known as Fraud and Abuse Detection Program)

In June 2000, the Department of Social and Health Services (DSHS) initiated implementation of a new automated payment integrity program (PIP). The Medical Assistance Administration (MAA) is playing a major support role in implementing the system and is committed to ensuring its providers that Medical Assistance payments are accurate and that program integrity is maintained.

With the increase in health care costs and demands by the public for increased accountability, accurate payments are essential. MAA continues to perform utilization and quality reviews on all categories of client service to ensure program integrity.

DSHS contracted with HWT, Inc. of Portland, Maine to implement PIP. PIP will assist in continually improving the DSHS payment integrity. In working with other states, HWT's experience has been that only a small percentage of providers are responsible for the majority of incorrect billings. DSHS believes the same to be true in Washington State.

PIP will be used first on claims that are processed and paid through MAA's Medicaid Management Information System (MMIS). Payment of claims processed outside the MMIS will occur at a later date.

The use of PIP is expected to result in the following opportunities that will benefit both providers and DSHS:

- Clarify and further streamline policies and procedures;
- Educate providers regarding proper billing practices;
- Increase program and payment integrity within DSHS programs; and
- Assure that Washington State will be able to continue to provide a wide range of covered services to those most in need.

More information about PIP is available on the DSHS website at http://maa.dshs.wa.gov/.

If you have questions or concerns regarding this project, you may contact any of the following PIP liaisons:

- Casey Zimmer, Manager, Quality Review
  Division of Health Services Quality Support
  Medical Assistance Administration
  Phone: 360-725-1552
  Email: zimmecl@dshs.wa.gov

- Ann Lawrence, Manager, Provider Relations
  Division of Program Support
  Medical Assistance Administration
  Phone: 360-725-1020
  Email: lawrea@dshs.wa.gov

- Sonja Gleizes, Supervisor, Review Unit
  Coordination of Benefits
  Division of Client Support
  Medical Assistance Administration
  Phone: 360-725-1180
  Email: gleizsm@dshs.wa.gov

- Catherine Ott, Deputy Manager
  Payment Integrity Program
  Administrative Services Division
  Management Services Administration
  Phone: 360-664-6081
  Email: ottcl@dshs.wa.gov

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Client Eligibility

What types of valid identification does MAA accept?

Following are five types of valid identification that a client in a medical assistance program can present to identify the medical program for which he/she is eligible:

1. A white Medical Assistance IDentification (MAID) card with green print, issued monthly by the state;

2. A yellow medical ID card with brown print, issued by the CSO/HCS;

3. A printout of a medical identification screen from the client's local CSO/HCS. To be valid, the printout must be marked by the CSO/HCS with a stamp identifying the location of the CSO/HCS;

4. An award letter from the CSO/HCS; **or**

5. Medical eligibility verification (MEV) receipt provided by an authorized MEV vendor for the date of service. (For more information on MEV, see next page.)

MAA strongly recommends you make a photocopy of valid identification for your file when it is presented to you.

Medical assistance program coverage is ***not transferable***.
If you suspect that a client has presented a card belonging to someone else, request to see a photo ID or another form of identification. ***Do not accept a MAID card that appears to have been altered***.

Medical Eligibility Verification (MEV) Services

- MEV services provide access to on-line MAA client eligibility data and can be purchased through approved MAA vendors. (See list of current vendors below.)

- MEV services provide you with necessary MAA client eligibility information for billing purposes. When you enter your provider number, access code, date of service and the client's name and birthdate and/or Social Security Number, you will receive eligibility status, availability of other insurance, managed care enrollment status, Medicare enrollment and other scope-of-care and program restriction information.

- Please contact these vendors directly for further information about their services. MAA updates the MEV vendor list as new vendors develop MEV services.

If the MAA client presents a valid MAID card, but does not appear on an MEV system, PLEASE do not deny the client access to services.

MEV Vendors

The following companies offer MEV services:

Blue Cross of WA/AK
7001 220th SW, MS 170
Mount Lake Terrace, WA 98043
Bob Crownheart (425) 670-4291

Healthcare Data Exchange (HDX)
300 Lindonwood Drive
Malvern, PA 19355
Jonas Dahlen (610) 219-9099

MedE America
2525 Midway Drive
Twinsburg, OH 44087
Jackie Brandon (216) 425-3241

Medifax (Potomac Group)
2525 Lebanon, Bldg. C, 2nd Fl
Nashville, TN 37214
Monica Cutrell (800) 444-4336
Fax: (615) 889-5601

National Data Corporation (NDC)
National Data Plaza
Atlanta, GA 30329
Jim Curran (800) 994-9100

Envoy
Rob Sikorski (615) 231-4746
Fax: (615) 231-4842

Provider Advantage (ENVOY)
(Washington Envoy Terminals)
3685 NW 183rd Avenue
Portland, OR 97229
(800) 366-5716
Ted Tompkins (503) 690-9716

Please contact these companies directly for further information about their services. MAA will keep you informed when new vendors develop MEV services.

Clients Enrolled in a Healthy Options Managed Care Plan

Many MAA clients are enrolled in MAA's managed care program called Healthy Options. These clients should have an HMO identifier in the HMO column on their MAID card.

- If the client is enrolled in a Healthy Options managed care plan, the name and telephone number of the plan will be indicated in the lower right portion of the MAID card.
- If the client is enrolled with a PCCM, the Primary Care Provider's name and telephone number will be listed.

Clients enrolled in Healthy Options must obtain the bulk of their services from their designated provider of service.

Managed Care Plan:

A client enrolled in Healthy Options will also receive an ID card from their plan. **Send all claims for services covered under the client's managed care plan to that plan for payment. (See Section A, for Healthy Options Managed Care Plan addresses).**

Note: If you treat a Healthy Options client and you are not the client's Primary Care Provider (PCP), or the client was not referred to you by the PCP, you may not receive payment. You will need to contact the PCP to get a referral. You may also need to get authorization from the plan for the service that you are providing, especially if you are not contracted as a provider with that plan. Call the managed care plan to discuss payment before you provide services.

Newborns of Healthy Options clients are the responsibility of the mother's plan for the first 60 days of life. If the mother changes plans, the baby follows the mother.

Primary Care Case Manager/Management:

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's MAID card for the PCCM.

Women enrolled in the PCCM model of Healthy Options must have a referral from their PCCM in order for women's health care services to be paid to an outside provider. The reason for this is the Indian clinics that contract as PCCMs do not meet the definition of health carriers in chapter 48.42 RCW. These clinics are excluded from the requirements spelled out in this act, including self-referrals by women to women's health care services.

Send PCCM claims for services to MAA-Division of Program Support for payment. (See Section H – How to bill for services provided to PCCM clients.)

Note: If you treat a Healthy Options client who has chosen to obtain care with a PCCM and you are not the PCP, or the client was referred to you by the PCCM/PCP, you may not receive payment. You will need to contact the PCP to get a referral.

Newborns of Healthy Options clients who are connected with a PCCM are fee-for-service until the client choose a PCCM for the newborn. All services should be billed to MAA.

Medical Assistance IDentification (MAID) Card

MAID Information

An individual, who meets DSHS requirements and is determined to be eligible for medical assistance, is issued a monthly Medical Assistance IDentification (MAID) card.

All Medical Assistance Administration (MAA) clients should present a MAID card to you prior to receiving services. The MAID card indicates the client's program and/or insurance coverage and other specific information.

Review the card **each month** for the following information:

- Beginning and ending eligibility dates (be sure to check for **current** month/year);
- The Patient Identification Code (PIC);
- Other specific information (e.g., Medicare, private insurance, Healthy Options coverage, or CHIP; and
- Retroactive or delayed certification eligibility dates, if any.

TAKE CHARGE MAID Information

TAKE CHARGE clients receive a MAID card yearly. The card will be annotated with the words TAKE CHARGE in section 19 (see sample MAID card on page D.2). This is to remind you that clients with TAKE CHARGE cards may only receive family planning services from a qualified TAKE CHARGE provider unless you are a pharmacy, laboratory, or ancillary service provider.

TAKE CHARGE clients are not eligible to be enrolled in a Healthy Options managed care plan.

The Medical Coverage Group Code is P06.

> Medical Assistance program coverage is ***not transferable***.
> If you suspect that a client has presented a MAID card belonging to someone else, request to see a photo ID or another form of identification. ***Do not accept a MAID card that appears to have been altered***.

Sample: Medical Assistance IDentification Card – (MAID)

Please read the back of this card

Medical Identification Card

This Card Valid From: **8/1/00** **2**

To: **8/31/00** **3**

1 411 E. Main Street
Anywhere, WA 98735

F06 4

PATIENT IDENTIFICATION CODE (PIC)				MEDICAL COVERAGE INFORMATION							
Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other
JR	**100790**	**PUBLI**	**A**			**PLAN**					
5	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**

HIC 544745145A

17

18 → J. R. Public
123 Main Street
Anytown, WA 98000

19 → CNP

20 →

21 → 1-800-555-6666 Plan

22 → 023 003455667

23 → L0000999 * 111234B

24 →

SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE

SIGNATURE (Not Valid Unless Signed)

DSHS 13-030 aces (04/95)

Key to the MAID Card

Field Description

1. Address of CSO/HCS/MEDS.
2. Date eligibility begins.
3. Date eligibility ends.
4. Medical coverage group.*

Patient Identification Code (PIC) Segments Are:

5. First and middle initials *(or a dash (-) if the middle initial is not known).*
6. Six-digit birth date, consisting of numerals only *(MMDDYY).*
7. First five letters of the last name *(and spaces if the name is fewer than five letters).*
8. Tie breaker *(an alpha or numeric character).*

Medical Coverage Information

9. **Insurance carrier code** - A four-character alphanumeric code *(insurance carrier code)* in this area indicates the private insurance plan information.*
10. **Medicare** - *Xs* indicate the client has Medicare coverage.
11. **HMO** *(Health Maintenance Organization)* – Alpha code indicates enrollment in an MAA Healthy Options or CHIP managed health care plan. ***(Managed health care plan is the same as Health Maintenance Organization or HMO.)*** This area may also contain the identifier PCCM *(primary care case manager).* The following ACES medical coverage groups, if not otherwise exempt, are required to enroll in Healthy Options: F01, F02, F03, F04, F05, F06, H01 and P02.* CHIP enrollment is limited to F07.
12. **Detox** - *Xs* indicate eligibility for a 3-day alcohol or a 5-day drug detoxification program.
13. **Restrictions** - *Xs* indicate the client is assigned to one physician and one pharmacist. The words, client on review, in field 20 will also indicate restricted clients.*
14. **Hospice** - *Xs* indicate the client has elected hospice care.*
15. **DD client** - *Xs* indicate this person is a client of the DSHS Division of Developmental Disabilities.
16. **Other** - This area is not in use.
17. **Health Insurance Claims (HIC)** number shown here indicates that the client is on Medicare.
18. **Name and address** of client, head of household or guardian.
19. **Medical program** and scope of care identifiers.*
20. **Other messages** *(e.g., client on review, delayed certification, emergency hospital only).*
21. **Telephone number** and name of PCCM or Healthy Options plan.
22. **Local field office** *(3 digits)* and ACES assistance unit # *(9 digits).*
23. **Internal control numbers** for DSHS use only.
24. **Client's signature** - May be used to verify identity of client.

*** See following pages for further details about this field.**

Field 4 – Medical Coverage Group

The codes below are the ACES medical coverage groups found in field 4. These codes identify the type of medical assistance the patient is receiving.

By identifying the client's medical coverage group, the provider can determine the need for additional services such as pregnancy-related First Steps services or if the patient is potentially a Healthy Options enrollee.

Medical Coverage Group Codes	Medical Coverage Group Definitions
C01, C95, and C99	Waivered and Community Based Programs such as CAP, COPES
D01 and D02	Foster Care and Adoption Support
F01, F02, F03, F04, and F09	Family Medical
F05, F06, F08, F95, F99, and H01	Children's Medical
F07	Children's Health Insurance Program (CHIP)
G01 and G02	General Assistance
G03, G95, and G99 facility (ALF)	Medical Assistance for a resident of Alternate Living Facility (ALF)
H01	Legal Guardian (children)
I01	Institution for the Mentally Diseased (IMD)
K01,K03,K95, and K99	Long Term Care - Families
L01, L02, L04, L95, and L99	Long Term Care – Aged, Blind, Disabled
M99	Medically Indigent (MI)
P02, P04, and P99	Pregnancy related
P05	Family Planning Only
R01, R02, and R03	Refugee
S01, S02, S07, S95, and S99	Aged, Blind, or Disabled (SSI)
S03, and S05	Medicare cost sharing
W01, W02, and W03	ADATSA

Field 9 – Insurance Carrier Codes

Some clients are covered under *private* health insurance plans. Premiums may be paid by the client, an absent parent, a relative, DSHS, or an employer.

Enrollment in a *private* HMO plan is indicated by an identifier beginning with ***HM*, *HI,*** or ***HO*** on the MAID card. Information can be located in *field 9* on an individual client level, and/or in *field 19* for all members of the family.

Third-party carrier code information is available on the DSHS-MAA web site at http://fortress.wa.gov/dshs/maa/Download/index.html. The information can be used as an on-line reference, downloaded, or printed. If you do not have access to MAA's web site, call 1-800-562-6136 and request that a hard copy or disk be mailed to you.
(corrected on-line 7/29/04)

Field 11 – Health Maintenance Organization (HMO)

Indicates enrollment in managed care through one of MAA's four managed care models:

- Basic Health Plus (BH Plus);
- Healthy Options;
- Children Health Insurance Program (CHIP); or
- Primary Care Case Management (PCCM).

Identifiers for HMO and BHP+ Plans are:

Plan Name	Healthy Options Identifier	BHP Identifier	CHIP Identifier
Aetna U.S. Healthcare	AUSH	AUSP	
Community Health Plan of Washington	CHPW	CHPP	CHPW
Clark United Providers *(Changing to Columbia United Providers 1/1/01)*	CUP	CUPP	
Group Health Cooperative	GHC	GHP	
Kaiser Foundation Health Plan	KFHP	KHPP	
Molina Healthcare of Washington *(formerly QualMed)*	MHC	MHCP	
Northwest Washington Medical Bureau	NWMB	NWMP	NWMB
Premera Blue Cross	PBC	PBCP	
Regence Blue Shield	RBS	RBSP	

1. The client must obtain all medical services covered under a managed health care contract with MAA through designated facilities or providers.

   The managed care plan is responsible for:

   - ✓ Payment of covered services; and
   - ✓ Payment of covered services referred by the plan to an outside provider.

2. Medical services not covered under the managed care plan's contract will be paid by MAA, if the services are covered benefits under the MAA fee-for-service program or CHIP, and meet MAA coverage requirements.

3. Medical services covered but denied by the managed care plan are not covered by MAA, if those services are covered benefits of the Healthy Options program.

Field 13 - Restricted

Clients who use medical services excessively or inappropriately may be assigned to the MAA Patient Requiring Regulation (PRR) program. The purpose of this program is to assist clients in using medical services appropriately. If a client is assigned to this program, there will be an X in the **Restricted** column and "Client on Review" will be printed in the **Other Messages** area of the MAID card.

These clients must select a primary physician and pharmacy to provide them with their medical services. Payment for services rendered by any physician or pharmacy other than the primary physician or pharmacy will be denied except in cases of emergency or referral by the designated physician.

Services provided by the following providers are **not** subject to restriction by the PRR program:

Dentists
Drug Treatment Facilities
Emergency Medical Services
Family Planning Agencies
Home Health Agencies
Hospitals
Medical Transportation Services
Mental Health Facilities
Optometrists
Other Medical Providers
(e.g., Durable Medical Equipment)

If you have questions about the PRR program or wish to report a client for utilization review call (360) 725-1780.

Field 14 - Hospice

The Hospice Program is available to clients in the Categorically Needy Program (CNP), Medically Needy Program (MNP), Children's Health Program, and CHIP.

Terminally ill clients with a life expectancy of six (6) months or less may choose to enroll in the hospice benefit program. When enrolled in the Hospice program, clients ***waive*** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness are coordinated and provided by the designated hospice agency and attending physician ***only***. Other providers ***will not be reimbursed*** by MAA for services related to the terminal illness. For further information, refer to MAA's Hospice Billing Instructions.

Only services **not** related to the terminal illness/Hospice diagnosis may be provided to clients on a fee-for-service basis, if covered under the client's MAA program. For a Healthy Options client enrolled in a Hospice Program, the provider should contact the client's plan for further information.

Field 19 - Medical Program and Scope of Care Identifiers

Medical Program Indicator	**Medical Program Name**
CNP	Categorically Needy Program
CNP Children's Health	Children's Health Program
CNP - CHIP	Children's Health Insurance Program
CNP Emergency Medical Only	CNP - Emergency Medical Only
Detox Only	Detox
EMER Hospital and Ambulance Only	Medically Indigent Program
Family Planning Only	Family Planning Program
GA-U No Out of State Care	General Assistance - Unemployable
General Assistance No Out of State Care	ADATSA, ADATSA Medical Only
LCP-MNP	Limited Casualty Program - Medically Needy Program
QMB – Medicare Only	Qualified Medicare Beneficiary - Medicare Only

See "Program Descriptions"
for further information on each program.

Field 20 - Delayed or Retroactive Certification:

Delayed Certification: A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

Retroactive Certification: An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

Field 21 – Telephone # and name of PCCM/Healthy Options plan

When a client is enrolled with a Primary Care Case Manager (PCCM), Healthy Options plan or CHIP, a PCCM or HMO identifier will appear in the *HMO* column.

The PCCM/Healthy Option plan name and telephone number will also appear in this area, which is located at the bottom right hand corner of the MAID card. The Healthy Options plan/PCCM will be identified only for the first client listed on the MAID card. Other family members on the MAID card may have a different PCCM. It is the provider's responsibility to obtain information about the other family members' PCCMs/Healthy Options plans from the client.

> **Note:** A newborn, born to women enrolled in a Healthy Options/PCCM program is fee-for-service and claims should be billed to MAA.

Program Descriptions

Categorically Needy Program (CNP)

CNP is a Medicaid program in which eligible individuals have full-scope medical/dental coverage (except Orthodontics). Eligible individuals include:

- **Aged -** Individuals 65 years old or older.
- **Blind -** Individuals who meet the social security requirement for blindness.
- **Children under age 19.**
- **Disabled -** Individuals who meet the social security requirement for disability.
- **Families with dependent children.**
- **Newborns -** Automatically eligible for CNP for 12 months if their mother received medical benefits at the time of the child's birth.
- **Pregnant women -** Eligible at any time during pregnancy.

CNP - Emergency Medical Only

This is a Medicaid program for persons who do not meet citizenship requirements but who are otherwise eligible for CNP. The scope of care is limited to services needed as a result of an emergent medical condition.

CNP - Qualified Medicare Beneficiaries (CNP-QMB)

This is a Medicaid program for certain, low-income individuals who are eligible for Medicare.

- If the service you provide is **covered by Medicare and Medicaid**, MAA will pay the deductible and coinsurance up to Medicare's or MAA's allowed amount, whichever is less.
- MAA will also reimburse for services that are **not covered by Medicare but are covered by Medicaid** under the CNP program.
- If the service is **covered only by Medicare and not Medicaid**, MAA will pay the deductible and coinsurance up to Medicare's allowed amount.

Children's Health Program (Children's Health)

(Not to be confused with the Children's Health Insurance Program – CHIP.)

Children's Health Program is a state-funded program for clients under the age of 18 who are not eligible for Medicaid.

Children's Health Insurance Program (CHIP)

(Not to be confused with the Children's Health Program.)
(Refer to WAC 388-542)

- CHIP is a federal/state program that covers medical services for children under age 19 in families whose income is too high for Medicaid, but is within 200 to 250% of the Federal Poverty Level. Children who have other medical coverage at the time of application are not eligible for CHIP.
- CHIP has the same scope of coverage as the Categorically Needy Program (CNP).
- CHIP requires families to pay copays directly to providers at the time of service and premiums to MAA, as described below.
- American Indian/Alaska Native (AI/AN) clients are exempt from paying client premiums and service copays.

Copays

CHIP client copays must be paid directly to providers, not to DSHS. Providers may choose to collect the copay at the time of service. Providers may refuse service to CHIP clients until copay is paid (**excluding emergency situations**).

- ✓ $5.00 for medical office visits with physicians, Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs), (i.e., CPT codes 99201-99215).
- ✓ $5.00 for non-generic (i.e., brand name or single source) drugs. (Generic drugs have $0 copay.)
- ✓ $25.00 for use of the emergency room that does not result in an inpatient hospital admission.

Note:

MAA does not require a copay for the following services:

1. Consultations (i.e., CPT codes 99241-99275);
2. Deliveries (births);
3. Dental;
4. Drug and alcohol treatment;
5. Generic drugs;
6. Inpatient and Outpatient surgery;
7. Mental health services (including services with psychiatrists or psychologists);
8. Occupational, physical, or speech therapy;
9. Office visits with age appropriate immunizations or exams for EPSDT (well-child check) screening;
10. Radiology; or
11. Visits to the emergency room that result in an inpatient hospital admission.

Premiums

CHIP client premiums are paid by the family to DSHS and are $10.00 per child, per month, with a family maximum of $30.00 per month. There is a grace period for non-payment, but clients who do not pay the premiums for four months are ineligible for CHIP.

Clients must send payments for their monthly premium to DSHS, Finance Division, PO Box 9501, Olympia, WA 98507-9727.

MAA's Division of Client Services, Medical Eligibility Determination Services (MEDS) staff makes all decisions regarding a client's eligibility due to non-payment of premiums.

The family's maximum out-of-pocket expense for CHIP premiums and copays is:

- $300.00 for one child enrolled in CHIP;
- $600.00 for 2 children enrolled in CHIP; or
- $900.00 for 3 or more children enrolled in CHIP.

Once a family reaches the out-of-pocket expense maximum, MAA will issue a letter to all children in the family that they are exempt from payment of copays and premiums until the end of the first child's 12-month eligibility period.

Families are responsible for tracking their out-of-pocket costs. If the family believes they have reached their 12-month out-of-pocket maximum, they should mail their receipts to:

Division of Client Support
Medical Eligibility Determination Section
PO Box 45531
Olympia, WA 98504-5531

Family Planning Only

This is a state-funded, family planning extension providing an additional 10 months of family planning services only, following a pregnancy for women who received MAA-paid medical benefits for the pregnancy. No other services will be covered.

General Assistance - Unemployable (GA-U) and Detox

GA-U and Detox are state-funded programs that provide medical and emergent dental services for general assistance unemployable persons receiving state cash assistance. These programs allow a limited scope of medical care within Washington State and border areas; out-of-state care is not covered.

Refer to MAA's specific program billing instructions for limitations. Border areas are listed on page A.19 of this General Information Booklet.

Limited Casualty Program (LCP)

LCP is also known as Medically Needy. This program provides medical care for individuals who do not meet the eligibility income/resource criteria for income assistance. The clients must be categorically-related to a federal program. Some clients must meet spend-down requirements before they become eligible. Spend-down is calculated based on income and resources. A MAID card is issued to the client when medical bills meet the spend-down and emergency medical expenses.

LCP has two components:

Limited Casualty Program - Medically Indigent Program (MIP) - This is a state-administered program for hospital-based services in which participants have a yearly, family, emergency medical expense requirement (EMER) to satisfy before medical coverage begins, in addition to the spend-down requirement. This program offers emergent inpatient care only. No out-of-state inpatient/outpatient hospital care is covered.

Limited Casualty Program - Medically Needy Program (LCP-MNP) - This is a Medicaid program that offers a limited scope of medical care. A MAID card is issued when medical bills meet the client's spend-down amount.

LCP-MNP - Emergency Medical Only

This is a Medicaid program for persons who are eligible for MNP but do not meet citizenship requirements. The scope of care is limited to hospital-based services relating to an emergency medical condition.

Medicare Cost Sharing Programs

Qualified Medicare Beneficiaries (QMB - Medicare Only)

This is a Medicaid program for certain, low-income individuals who are also eligible for Medicare. The reimbursement criteria for this program is as follows:

- **If the service you provide is covered by Medicare and Medical Assistance**, MAA will only pay the deductible and coinsurance, up to the Medicare or MAA allowed amount, whichever is less.

- **If the service is covered only by Medicare and not Medical Assistance**, MAA will only pay the deductible and coinsurance up to Medicare's allowed amount.

- **If the services you provide are not covered or are denied by Medicare**, MAA does not make any reimbursement.

Special Low-Income Medicare Beneficiary (SLMB)

This is an MAA program for certain, low income individuals who are also eligible for Medicare and meet the income levels (100-119% FPL). MAA will pay Medicare Part B premiums. Clients can be dual-eligible (e.g., SLMB and LCP-MNP).

Expanded Special Low-Income Medicare Beneficiary (ESLMB)

This is an MAA program for certain, low-income individuals who are also eligible for Medicare. MAA will pay Medicare Part B premiums. Clients must meet the same income requirements as the SLMB program, but they **can not be dual eligible**.

TAKE CHARGE

TAKE CHARGE is a federal/state funded family planning only program. Only family planning and family planning related services are covered. TAKE CHARGE services are available to both men and women.

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Authorization

What is prior authorization?

Prior authorization is MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization and limitation extensions are forms of prior authorization.**

MAA requires providers to obtain prior authorization for many services, items, and supplies (as identified in MAA's specific program billing instructions) *before* providing them to the client.

Call the appropriate telephone number listed below to obtain authorization for these services or items. **If you are the provider of a service, it is your responsibility to obtain authorization.**

Note: **Authorization for services does not guarantee payment. Prior authorization is for approving the service or equipment for medical necessity.** Providers must meet administrative requirements (client eligibility, claim timeliness, third party insurance, etc.) before MAA will reimburse for services.

To Request Prior Authorization, Call:

1-800-634-1398	Acute Physical Medicine and Rehabilitation (PM&R)
1-800-292-8064	Durable Medical Equipment (DME) and Prosthetics & Orthotics.
1-800-848-2842	Pharmaceutical/Drugs

Note: Hospice requires provider notification within 5 days of the client's admittance to, or discharge from, the Hospice agency or upon death. Providers must fax the completed 5-day notification (see Hospice Billing Instructions) to: (360) 586-2262 or call (800) 545-5392.

What is expedited prior authorization?

MAA is using the expedited prior authorization (EPA) process for some procedures and diagnoses. The EPA process is designed to eliminate the need for live telephone prior authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an EPA number, when appropriate. Below are examples of services and supplies that have an established EPA process. Refer to the specific MAA billing instruction for the EPA criteria.

- Ambulatory Surgery Centers
- Physical Therapy
- Prescription Drugs
- Medical Admits, MRI/MRAs, and Surgeries
- Occupational Therapy
- Severe Malocclusions (for Orthodontists only)
- Rental of Certain Durable Medical Equipment & Supplies

The following are examples of administrative costs and are included in the reimbursement for another service:

- Missed or canceled appointments;
- Elective or planned out-of-state inpatient care;
- Mileage;
- Take-home drugs;
- Educational supplies or services;
- Copying expenses, reports, client charts, insurance forms;
- Service charges/delinquent payment fees;
- Telephoning for prescription refills; and
- Specific areas as specified in MAA fee schedules.

What are limitation extensions?

Limitation extensions are cases when a provider can verify that it is medically necessary to provide more units of service (quantity, frequency, or duration) than allowed in MAA's billing instructions and Washington Administration Code (WAC).

Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups receive all services.

How do I request a limitation extension?

There are two ways to request a limitation extension:

1) Providers may be able to obtain authorization for these limitation extensions using an expedited prior authorization number. These EPA numbers will be subject to post payment review as in any other authorization process. (See MAA's specific program billing instructions to see if the EPA process is an option.)

2) In cases where the client's situation does not meet the EPA criteria for a limitation extension, but the provider still feels that additional services are medically necessary, the provider must request MAA-approval in writing.

The request must state the following in writing:

1. The name and PIC number of the client;
2. The provider's name, provider number and FAX number;
3. Additional service(s) requested;
4. Copy of current audiogram for both ears and the date the last hearing aid(s) were dispensed;
5. The primary diagnosis with CPT or state assigned code of the requested service; and
6. Clinical justification for additional services.

Send your written request for a limitation extension to:

Division of Health Services Quality Support
Quality Fee for Service Section
Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Telephone (360) 725-1583
Fax (360) 586-2262

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Transportation
(non-emergent/non-ambulance)
and Interpreter Services

The Transportation and Interpreter Services Section (TISS) within the Medical Assistance Administration (MAA) provides services which assure equal access to DSHS programs and services. This applies to all persons, including those with limited English proficiency (LEP), deaf, deaf-blind, hard of hearing, and persons without transportation to get to their medical appointments. MAA is committed to ensuring that all MAA clients have equal access to medical care.

What is the cost to the client?

Transportation and interpreter services are available at no cost to the client.

Who is eligible for these services?

All MAA clients qualify for transportation and interpreter services.

Transportation Services

The transportation program:

- Assures access to necessary non-emergent medical services for all MAA clients who have no other method of transportation.
- Provides non-emergent, non-ambulance transportation.
- Includes different methods of transportation, including:

  - ✓ Public transit;
  - ✓ Sedans (passenger vehicles);
  - ✓ Vans with and without lifts;
  - ✓ Volunteers; and
  - ✓ Mileage reimbursement.

- Provides the least costly transportation appropriate to the client's medical condition.
- Requires client to contact a Transportation Broker (see the list on next page) at least 48 hours ahead of medical appointment.
- Is coordinated to serve more than one client on a trip, when possible.
- Requires a client to notify the Transportation Broker at least 24 hours ahead of appointment to cancel.

MAA covers transportation services when:

- The client is an eligible MAA client; and
- The client is going to a medical appointment covered by the client's MAA program; and
- The transportation broker has coordinated and pre-authorized the service.

MAA does not cover transportation services when the transportation is provided for medical services that are:

- Not medically necessary; or
- Not covered by the client's MAA program.

Transportation Brokers

The Medical Assistance Administration holds administrative contracts with certain **transportation brokers**. In accordance with those contracts:

- All non-emergent, non-ambulance transportation to and from covered medical services must be arranged by a broker.
- Transportation brokers provide or arrange all transportation originating within specific counties (see following pages).
- Clients or their representatives must contact the broker directly for their transportation needs.
- MAA does not reimburse non-ambulance transportation providers directly. MAA reimburses brokers.

Non-emergent, non-ambulance medical transportation is the responsibility of the brokers, except in the following instances:

- The client or his/her representative must call MAA's Quality Support Section at (360) 725-1552 for out-of-state commercial air transportation (except border areas).

- Client transportation for admission under the Involuntary Treatment Act (ITA) is the responsibility of the Division of Mental Health Services and is handled by special, local ITA providers, where available.

The list on the following pages is a list of MAA's Transportation Brokers for each county in the state and the telephone numbers for those companies.

TRANSPORTATION BROKER LIST

State of Washington **Department of Social and Health Services** **Medical Assistance Administration** **Division of Client Support** **Transportation And Interpreter Services** **PO Box 45534** **Olympia, WA 98504-5534**		Paul Meury, Program Manager Phone: (360) 725-1317 MEURYPA@DSHS.WA.GOV	Becki Jorgenson, Administrative Assistant Phone: (360) 725-1312 JORGERJ@DSHS.WA.GOV
	Diane Kessel, Program Manager Phone: (360) 725-1318 KESSEDC@DSHS.WA.GOV	James E. Smith III, Program Manager Phone: (360) 725-1319 SMITHJE@DSHS.WA.GOV	FAX: (360) 664-0261 **MEDICAL ASSISTANCE CUSTOMER SERVICE TOLL FREE LINE: 1-800-562-3022**

BROKER	REGION/ COUNTIES COVERED	BROKER TELEPHONE NUMBERS
Coast Transportation PO Box 107 Colfax, WA 99111	**REGION 13** Asotin, Garfield, and Whitman	**VOICE AND TDD:** 1-800-873-9996 (509) 397-2935 **FAX:** (509) 397-9229
Human Services Council Medical Transportation PO Box 425 Vancouver, WA 98666-0425	**REGION 7** Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum	**VOICE and TDD:** 1-800-752-9422 (360) 694-9997 **FAX:** (360) 694-6716
Hopelink Bellevue, WA 98007	**REGION 3** King	**VOICE:** 1-800-923-7433 (425) 861-1454 **TDD:** 1-800-246-1646 **FAX:** (425) 644-9447
NW Regional Council Area Agency On Aging Bellingham, WA 98225	**REGION 1** Island, San Juan, Skagit, and Whatcom	**VOICE:** 1-800-860-6812, 1-800-585-6749* (360) 738-4554 (Whatcom only) **TDD:** 1-800-860-6812, 1-800-585-6749* (360) 676-6749 (Whatcom only) **FAX:** (360) 738-2451

BROKER	REGION/ COUNTIES COVERED	BROKER TELEPHONE NUMBERS
Paratransit Services Bremerton, WA 98312	**REGION 4** Pierce **REGION 5** Clallam, Jefferson, Kitsap, and North Mason **REGION 6** Pacific, Thurston, Lewis, Grays Harbor, and South Mason	**VOICE:** (360) 377-7007 (All counties) 1-800-756-5438 (Mason-North, Kitsap) 1-800-436-7272 (Clallam, Jefferson) 1-800-846-5438 (Grays Harbor, Lewis, Mason-South, Pacific, Thurston) 1-800-925-5438 (Pierce) **TDD:** All Counties1-800-934-5438 **FAX:** (360) 377-1528 or (360) 377-6017
People For People PO Box 1665 Yakima, WA 98907	**REGION 8** Kittitas, Yakima, Benton, Franklin, Walla Walla, and Columbia **REGION 11** Grant, Lincoln, and Adams	**VOICE:** 1-800-233-1624 (509) 248-6793 **TDD:** 1-800-606-1302 (509) 453-1302 **FAX:** (509) 574-5085
Snohomish County Transportation Everett, WA 98201	**REGION 2** Snohomish	**VOICE:** 1-800-794-8818 (425) 388-7267 **TDD:** (425) 388-7333 **FAX:** (425) 388-7414
Special Mobility Services Spokane, WA 99202	**REGION 10** Ferry, Pend Oreille, and Stevens **REGION 12** Spokane	**VOICE:** 1-800-892-4817, (509) 534-9760 **TDD:** 1-800-821-7167 (509) 534-8566 **FAX:** (509) 534-6980, 1-888-829-9915
Trancare Wenatchee, WA 98801	**REGION 9** Chelan, Douglas, and Okanogan	**VOICE:** 1-800-352-8726 (509) 667-2727 **FAX:** (509) 667-2083

Interpreter Services

Interpreter services:

- Must be provided only by DSHS-certified or qualified interpreters;
- Require all information to be kept confidential;
- Require the medical provider and client to decide together if an interpreter is needed;
- Must be arranged for by the medical provider; and
- Require the medical provider to cancel or change the interpreter appointment, if necessary, within 24 hours of the scheduled appointment.

MAA covers interpreter services when all of the following are met:

- The LEP, deaf, deaf-blind, or hard of hearing person is an eligible MAA client;
- The client and the medical provider have decided an interpreter is needed to access necessary medical and health care services covered by the client's MAA program; and
- The interpreter services (spoken languages) are provided by a DSHS contractor/subcontractor.

MAA does not cover interpreter services when:

- Requested by someone other than the medical provider;
- Provided for medical services that are not medically necessary;
- Provided for services that are not covered by the client's MAA program;
- Provided by a family member;
- Not required by the medical provider to communicate with an MAA client (provider speaks same language as client); or
- Provided by an interpreter who is not qualified or certified.

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- Providers must submit initial claims and adjust prior claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- Providers must submit their claim to MAA and have an Internal Control Number (ICN) assigned by MAA within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

> ☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service. (See Rebillings and Adjustments, Section K.)

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

Note: Newborns of Healthy Options clients that are connected with a PCCM are fee-for-service until a PCCM has been chosen. All services should be billed to MAA.

Billing an MAA client on a fee-for-service program

[Refer to WAC 388-502-0160]

First, determine if the patient is an MAA client.

It is very important to determine if the patient is a Medical Assistance client. If the patient is an MAA client, ask the client to bring his or her Medical Assistance IDentification (MAID) card to the appointment. If the client forgets to bring the MAID card, the provider should check eligibility with available systems (Medical Eligibility Verification or Point of Sale) or, if it is not an emergency situation, ask the client to return with the MAID card.

Since eligibility for Medical Assistance is on a month to month basis, you need to verify eligibility each visit, and may want to keep a photocopy of the client's current MAID card. It is important to check the medical program coverage listed on the client's MAID card. A client may be eligible for the full scope of service one month, eligible for a limited scope program such as Family Planning the next month, or not eligible at all.

Check the Insurance and Medicare Columns on the MAID Card
Does the client have either private insurance or Medicare? If so, these are the primary payors and must be billed first.

If the client is enrolled in a Healthy Options managed care plan, you may need a referral and/or authorization from the plan to provide care for services provided through the Healthy Options contract, except for emergency room visits. If the service is not an emergency and you do not have a referral or authorization, refer the client back to the client's plan or primary care provider (PCP), unless the client is seeking a service for which self-referral is permitted under the Healthy Options contract.

Check the MAID card to determine if the client is enrolled in the Children's Health Insurance Program (CHIP).
If the client is enrolled in CHIP, they are responsible for paying any appropriate copays directly to the provider, not MAA. Refer to page E.2 for additional information on CHIP copays. The CHIP identifier is located on the lower right-hand corner of the MAID above the signature line. The identifier reads "CHIP."

Reminder

- One of the most common billing complaints is from clients who receive bills from laboratories or radiologists because the ancillary providers did not receive a copy of the MAID card. Please remember that it is the medical provider's responsibility to forward a copy of the MAID card to all ancillary service providers (e.g., radiology, and laboratory) when the provider orders these services.

- Another common billing complaint is the pharmacist misinterpreting a Point-of-Sale (POS) message as a denial and billing the client instead of calling MAA for prior authorization. Please remember that it is the pharmacist's responsibility to call MAA for prior authorization (PA) when the pharmacist receives a PA message from the POS system.

Refer to WAC 388-502-0160

- A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay for the service because the provider failed to satisfy the conditions of payment in MAA billing instructions, in chapter 388-502 WAC, and other chapters regulating the specific type of service provided.

- The provider is responsible to verify whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

- A provider may bill a client only if one of the following situations apply:

  ✓ The client is enrolled in a managed care plan and the client and provider comply with the requirements in WAC 388-538-095;

  ✓ The client is enrolled in a medical program, is not enrolled in a managed care plan, and the client and provider sign an agreement. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for DSHS review upon request.

  The agreement must include each of the following elements to be valid:

  - ➢ The specific service to be provided;
  - ➢ The service is not covered;
  - ➢ The client chooses to receive and pay for the specific service; and
  - ➢ The client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider for the service because the provider did not satisfy MAA's billing requirements.

  ☞ **Note: A sample "Informed Consent Form – Agreement to Pay for Noncovered Services or Items" has been provided on page H.7.**

  ✓ The client or the client's legal guardian was reimbursed for the service directly by a third party;

- ✓ The provider has documentation that the client represented himself/herself as a private pay patient when the client is already eligible for and receiving benefits under a DSHS medical program. The documentation must be signed by the client or the client's representative. The provider must maintain the original documentation in the patient's file for DSHS review upon request.

- ✓ The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. Medical Assistance is not insurance;

- ✓ The bill counts toward a spend-down liability, emergency medical expense requirement, deductible, or copayment required by MAA.

- If a person becomes eligible for a service that has already been provided due to:

  - ✓ Retroactive certification[1], the provider:

    - ➢ Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and
    - ➢ May refund any payment received from the client or anyone on the client's behalf, and then bill MAA for the service.

  -or-

  - ✓ Delayed certification[2] [or any other reason other than retroactive certification], the provider must:

    - ➢ Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
    - ➢ Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service.

☞ **Note:**	Many people apply for a medical program *AFTER* receiving covered medical services. The department may take as long as 45 to 90 days to process medical applications. If eligible, the client receives a MAID dated the first of the month of application. The MAID is *NOT* noted with either the "retroactive certification" or "delayed certification" identifiers. Providers must treat these clients as the "delayed certification" procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

[1]**Retroactive Certification** – The three calendar months before the month of application. (WAC 388-500-0005)

[2]**Delayed Certification** – Department approval of a person's eligibility for Medicaid made after the established application processing time limits. (WAC 388-500-0005)

- Hospitals may not bill, demand, collect, or accept payment from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spend-down.

- A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.

  This includes, but is not limited to:

  (a) Medical charts;
  (b) Radiological or imaging films; and
  (c) Laboratory or other diagnostic test results.

INFORMED CONSENT

Agreement To Pay for a Noncovered Services or Item

(For fee-for-service clients)

This form must be completed in full before providing a noncovered service or item to a Medical Assistance client.

CLIENT NAME:_____ ID NUMBER/PIC:_____

- ✓ I understand that the specific services listed below **are not** covered by my medical assistance program and are not included as part of another service, or have been determined by MAA to not be medically necessary.
- ✓ I choose to receive these specific services.
- ✓ I agree to pay for these specific services.

SPECIFIC SERVICES CLIENT AGREES TO RECEIVE AND PAY FOR:

This agreement is void and unenforceable, and I am under no obligation to pay the provider**, if** my medical program covers the services listed above or if the provider fails to satisfy DSHS conditions of payment as described under WAC 388-502-0160.

I understand this form and all my questions were answered to my satisfaction.

SIGNATURE OF CLIENT/PARENT/ GUARDIAN/REPRESENTATIVE	**DATE**

SIGNATURE OF PROVIDER	**PROVIDER NUMBER**	**DATE**

***Note to Providers**: The services or items listed above **must** be specific in nature. Document steps taken to assure that the client fully understands this form and that the form has been interpreted and/or translated, as necessary. For Healthy Options managed care clients, see WAC 388-538-095(5).*

How do I bill for clients eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance, for services covered by Medicare **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims (see page H.1).

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Note: Effective April 1, 1999, payments for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service (whether normally DRG or RCC reimbursed) had the service been reimbursed under the ratio of costs-to-charges (RCC) payment method.

When billing Medicare:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the MAID card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing. (See page A.3)
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

NOTE:

- ✓ **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA waives the prior authorization requirement but still requires authorization. Authorization or denial of your request is based upon medical necessity.

  NOTE:

  - ✓ **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.**
  - ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medical Assistance does not exceed Medicare or MAA's allowed amount, whichever is less.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their MAID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA pays only the deductible and/or coinsurance up to Medicare or MAA's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA pays only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only Medicaid **and not Medicare** cover the service and the service is covered under the CNP or MNP program, MAA reimburses for the service.

QMB-Medicare Only

- If Medicare **and** Medicaid cover the service, MAA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare does not** cover the service,
MAA does not reimburse the service.

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Medical Assistance Administration (MAA)
Division of Program Support • Office of Claims Processing

BILLING CLAIM FORMS REQUEST

Fill out this form in ink.

ELECTRONIC BILLING INFORMATION

MAA accepts various methods of electronic billing. These methods of filing claims are both fast and economical. Providers interested in electronic billing may call the following number: (360) 753-0318.
THIS TELEPHONE NUMBER IS FOR ELECTRONIC BILLING INFORMATION ONLY, NOT FOR ORDERING FORMS.

We do not accept telephone orders.

If you are ordering forms for more than one provider, attach a list showing each provider number. Indicate the number of forms you need; otherwise, the quantity of forms sent will be based on the number of claims submitted within the last six months to the MAA Office of Claims Processing.

FOR USE IN BILLING FOR MEDICAID RECIPIENTS ONLY

QUANTITY	FORM NO. AND TITLE	
	HCFA-1500 INVOICE - Medicaid Only	(OPS-2)
	HCFA-1500 INVOICE (Continuous for Computer Billing) - Medicaid Only	(OPS-7)
	525-109 ADJUSTMENT REQUEST - Blue	(OPS-3)
	525-106 PHARMACY STATEMENT	(OPS-1)
	525-106 PHARMACY STATEMENT (Continuous for Computer Billing)	(OPS-5)
	DIRECT ENTRY - BATCH HEADER BACKUP DOCUMENTATION SHEET	
	DIRECT ENTRY - BACKUP DETAIL SHEET	
	DIRECT ENTRY - CLIENT LISTING	

RETURN COMPLETED FORMS REQUEST TO:

Medical Assistance Administration
Division of Program Support
Office of Claims Processing
P O Box 45560
Olympia WA 98504-5560

UPS Delivery Only
Medical Assistance Administration
Division of Program Support
Office of Claims Processing
617 Eighth Avenue SE
Olympia WA 98504-5560

Allow three to five weeks for delivery.

This portion of the form will be the mailing label for your order. **You must indicate a street address for United Parcel Service (UPS) delivery.** UPS WILL NOT DELIVER TO A POST OFFICE BOX ADDRESS.

(WRONG PROVIDER NUMBER CAUSES UNDUE DELAY)

PROVIDER NAME			PROVIDER NO. (SEVEN-DIGIT)
STREET ADDRESS *(Required for UPS Deliveries)*			TELEPHONE ( )
CITY	STATE	ZIP CODE	ATTENTION

DSHS 17-101A (REV.04/2000)

Third-Party Liability (TPL)

The Medical Assistance Administration (MAA) is required by federal regulation to determine the liability of third-party resources that are available to MAA clients. All resources available to the client that are applicable to the costs of medical care must be used. Once the applicable resources are applied, MAA may make payment on the balance if the third-party payment is less than the allowed amount.

To be eligible for MAA programs, a client must assign his/her insurance rights to the state in conformance with federal requirements.

It is the provider's responsibility to bill MAA appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated on the MAID card; or
- There is a possible casualty claim; or
- You believe insurance is available.

> If you would like assistance in identifying an insurance carrier, call the Third-Party Resource Program at 1-800-562-6136, or refer to the TPL Carrier Code List on MAA's web site at http://maa.dshs.wa.gov.

Exception:

Due to federal requirements, the following services will <u>not</u> be denied for third-party coverage <u>unless</u> the TPL code is **HM, HI, or HO:**

- ✓ Outpatient preventative pediatric care;
- ✓ Outpatient maternity-related services; and
- ✓ Accident related claims, if the third party benefits are not available to pay the claims at the time they are filed, per 42 CFR 433.139(c).

Indicate all available insurance information on the claim form. MAA pays the claim and pursue the third-party insurance.

> **For further information, refer to MAA's specific program billing instructions.**

You must pursue collection from the subscriber when the client is not the subscriber and the insurance company makes a benefit payment to the subscriber. Under these circumstances, the client is under no obligation to pay unless he/she is the insurance subscriber.

Although the billing time limit for MAA is 365 days, an insurance carrier's time limit on billing allowances may be different. It is your responsibility to meet the insurance carrier's requirement relating to billing time limits prior to any payment by MAA.

☞ **Note:** If you receive payment from MAA in excess of the amount due, you may refund the excess to the Office of Financial Recovery, or you may submit an adjustment request to MAA to withhold money from future checks. A copy of the appropriate MAA Remittance and Status Report showing the original payment and copy of the insurance EOB, if available, should be attached to either the check or the adjustment request, whenever possible.

Mail refund checks to:

OFFICE OF FINANCIAL RECOVERY - MED
PO BOX 9501
OLYMPIA WA 98507-9501

Types of Insurance Claims

Casualty Claims

MAA considers claims with possible trauma-related injury diagnosis codes (ICD-9-CM, 800 - 990) as casualty claims. When you submit your claim to MAA, attach a completed injury report to help MAA resolve third-party liability issues. **Casualty claims routinely investigated for possible third-party coverage are:**

- Motor vehicle accidents;
- Accidents occurring in a place of business, public building, in the home or on the property of another person;
- Litigation involving a malpractice claim;
- Department of Labor and Industries claims;
- Injury diagnoses and services performed in a hospital; and
- Injury diagnoses and claims over $30.00.

While your claim is pending investigation, call only if you have **additional** insurance information. When the investigation is completed, MAA makes payment or provide you with the name and address of the party responsible for payment.

If you receive payment from an insurance company for services that have been paid by MAA, immediately refund to MAA either MAA's payment or the insurance payment, whichever is less. If the refund is not made within thirty (30) days, MAA recovers the lesser payment.

On-line update 11/08/04

Health Insurance Claims

Third-party liability claims other than those for trauma-related injuries are considered health insurance claims. **These claims are routinely held for Third-Party Resources (TPR) investigation when:**

- MAA's records indicate insurance benefits are available through a third party; or
- Other resources are indicated on the claim or attachment (name of insurance company, insurance pending, etc.).

CHAMPUS

The Washington State Medicaid program coordinates benefits with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in a special way. When an MAA client is also CHAMPUS-eligible, the identifier **CH01, HI50, or HI01** will appear in the Insurance area of the MAID card.

Active duty military clients have an insurance designation of HI00 on their MAID cards. These clients need to be directed to use their military facility. Emergent or referred services for clients with HI00 should be billed to the military.

When you are presented with a MAID card indicating CHAMPUS coverage, or you are aware of the client's CHAMPUS eligibility, you should determine the following:

1. What is the client's zip code area? (Known by CHAMPUS as the catchment area.) Residents with certain zip codes are required to obtain non-emergent hospital inpatient services from the local military hospital. If residents with these zip codes do not go to a local military hospital for treatment, they must obtain a CHAMPUS DD Form 1251 - Nonavailability Statement. MAA requires this form prior to making payment on these claims. Form 1251 is *not* required for emergent hospital inpatient services or other medical services not requiring hospitalization.

2. Is the client enrolled in DEERS (the Defense Enrollment Eligibility Reporting System)? DEERS eligibility is required by CHAMPUS before CHAMPUS will make payment. To receive reimbursement from MAA for services provided to CHAMPUS ineligible clients, you should obtain a written denial from CHAMPUS. The denial will state *"Sponsor not on DEERS or not enrolled in DEERS."* Claims submitted to MAA with these denials attached will be paid by MAA according to departmental policies.

> ***NOTE*:** When dealing with CHAMPUS/DEERS clients, ask to see the client's military ID card to determine current military status; this information may be useful for billing CHAMPUS. Look at both sides of the military ID card for essential information related to service restrictions. **If you have additional questions regarding CHAMPUS requirements, you may call the TPR toll-free line at 1-800-562-6136.**

Veteran's Affairs

The Washington State Medical Assistance program coordinates benefits with the Department of Veterans Affairs (VA) in a special way. When a client of one of MAA's medical programs is also VA eligible, the identifier **VE02** appears in the Insurance area of the MAID card.

When you are presented with a MAID card indicating Veterans Administration or you are aware of the client's VA eligibility you should:

Obtain current information on VA benefits and claims procedures by calling the nearest VA regional office. A call to (800) 827-1000 from any location in the United States will be automatically routed to the nearest VA regional office. VA medical center admissions offices are the primary source for information regarding medical care eligibility. They can provide information on all types of medical care, including nursing home coverage. Many VA medical centers operate outpatient clinics either in the office or in other locations. Individuals with VA eligibility are required to seek medical care through their VA providers as **their primary insurance**.

HMO-Related Claims (Other than Healthy Options)

Some MAID cards will display an **HM, HI, or HO** identifier in the insurance area of the MAID card. This indicates that the client is enrolled in a managed health care plan. Clients enrolled in a managed health care plan must comply with the requirements of their plan.

- All medical services covered under the managed health care plan must be obtained through the designated facility or provider. MAA does not pay for services referred to an outside provider by an HMO. This is the responsibility of the referring HMO.

- MAA may pay for services not covered by the managed health care plan if MAA covers the services. (See specific program billing instructions.)

For further information, refer to your specific program billing instructions.

Exception: HMO clients living outside of the HMO catchment area (within a 25 mile radius of the nearest HMO facility) will be coded with **HM99**. Only emergent services provided to these clients are payable by the HMO. The HMO requires proper notification of any emergent services before they make any payment(s). MAA considers payment for non-emergent services for these clients.

You are responsible for obtaining notification approval from the managed health care plan. Usually this must be done within 48-72 hours from the time the service was provided.

Multiple Services

When multiple services are provided, you must itemize each service and indicate the applicable third-party reimbursement for each service. MAA reimburses for covered services according to the maximum allowable rate listed in MAA's specific program billing instructions.

Rebilling

If the insurance reimbursement amount is less than the MAA allowance or the charges are denied by the third-party resource, resubmit the claim to MAA. **Remember!** Indicate **Insurance** in the appropriate box on the claim form or electronic record so the claim will be processed properly. When billing electronically, put a **Y** in the TPL field.

When submitting a rebilling that is beyond the 365-day billing time from the date of service, reference the Internal Control Number (ICN) that reflects the specific denial (or attach the Remittance and Status Report) that verifies that your claim was originally submitted within the time limit. (Note: If rebilling electronically, the ICN should be indicated in the *Remarks/ Comments* field.) **Claims with potential insurance coverage will be denied if they are submitted without attached insurance information.** For specific information on rebilling claims and submitting adjustments, refer to the Rebillings and Adjustments (Section K) of this booklet.

Remittance and Status Report

All third-party liability claims appearing on your Remittance and Status Report, in the *Claims in Process* section, with the name and address of the insurance company will be denied with the following EOB:

090 - Bill this claim to the insurance company as instructed unless documentation is attached to the claim or is on file to warrant payment of the claim.

For further information about the Remittance and Status Report, refer to Section J, Remittance and Status Report.

Evidence of Insurance Termination

When any insurance coverage for the client has been terminated, forward a copy of the termination notice from the insurance company or call the TPR toll-free line at **1-800-562-6136**. Assistance in keeping our information accurate is appreciated.

The following documents (or photocopies of them) may be used as verification of insurance termination:

1. EOB statements from insurance companies
2. Letters from employers
3. Memos from CSOs or insurance companies
4. Divorce decrees
5. Court orders
6. Military discharge papers *(DD214)*
7. Client-specific letters on insurance company letterhead

Third-Party Time Limits

Although the billing time limit for MAA is 365 days, an insurance carrier's time limit on billing allowances may be different. MAA has no payment responsibility for late filings with private carriers.

Bill the insurance carrier indicated on the MAID card. You must meet MAA's 365-day billing time limit, even if you have not received the insurance carriers notification of action. If your claim is denied due to any existing third-party liability, refer to the Remittance and Status Report for insurance information appropriate for the date of service.

Requesting Reimbursement

MAA's decision to make or deny payment when third-party resources are involved depends on the reimbursement amount paid by the third party.

- When the insurance payment is less than MAA's maximum allowable rate for the services performed, MAA pays the difference between the third-party payment and MAA's maximum allowable rate.

- When the third-party payment is as much as or more than MAA's maximum allowable rate, MAA considers the claim paid in full. MAA makes no further payment. The client may not be billed for balances.

- MAA pays sales tax for taxable items on the allowed amount minus the insurance payment. When indicating the insurance payment, exclude any sales tax the insurance company paid to you.

Questions and Answers

1. **Where does DSHS get third-party information?**
   From clients, employers, medical providers, and special data matches.

2. **How can the provider of service assist MAA in updating TPL records?**

   - By forwarding the insurance carrier's EOB or correspondence to the Third-Party Resource (TPR) Program.
   - Call TPR (toll-free) at **1-800-562-6136** with any informational updates that apply.
   - Clients may also call the above toll-free line.

   Note*:* Any information received is subject to verification by MAA.

3. **How can someone on Medical Assistance also have health insurance coverage?**

   - Through his/her employer (if his/her income allows him/her to qualify for assistance).
   - Through an absent parent.
   - Through other family members.
   - As a result of health care reform activities.
   - DSHS pays premiums for those clients who have a health insurance plan available to them which meets the department's criteria for cost effectiveness.

4. **How can I determine if the client has third-party liability?**

   - By asking the patient at the time the service is given.
   - By checking the MAID card.
   - By contacting TPR at **1-800-562-6136**.
   - By using the Medical Eligibility Verification System (MEVS). To find out more about MEVS, see page C2.

5. **Must third-party resources be used before MAA pays?**

   Yes, all resources available to the client must be used prior to payment by MAA unless federal exceptions apply. (See page I.1.)

For further information, refer to MAA's specific program billing instructions.

6. **What can I do as a provider to facilitate processing of third-party claims?**

- Prepare the claim according to appropriate billing instructions.
- Submit all backup information regarding each claim (RAs, EOBs, accident reports, etc.) if available; or submit appropriate remarks.
- Make sure the date(s) on the insurance information (e.g., RAs, EOBs, accident reports) correspond to the date(s) on the claim.

7. **What can I do when I haven't received a payment from the insurance company?**

- The client has assigned all medical insurance/medical support to the department when he/she became eligible for MAA services. As a result, the client's cooperation is required to maintain continued eligibility.
- If an insurance company is not cooperative, call the Third-Party Resource's toll free number: **1-800-562-6136**.

8. **What can I do when the client or subscriber is not cooperative?**

- The client has assigned all medical insurance/medical support to the department when he/she became eligible for MAA services. As a result, the client's cooperation is required to maintain continued eligibility.
- If the client is not cooperative, call the Third-Party Resource's toll free number: **1-800-562-6136**.

9. **How can I avoid recoupment of payments made by an insurance company?**

If you receive payment from an insurance company for services that MAA has paid, immediately refund to MAA either MAA's payment or the insurance payment, whichever is less.

10. **May I bill the client when insurance doesn't pay?**

- No, you must bill MAA for covered medical services.
- You may bill the client for noncovered services *if* the client has chosen to receive and has agreed to pay for these services in writing ***before*** receiving the services. (See Section H, Billing.)

11. **What do I do if the client receives an insurance payment and does not pay me?**

If the client is the subscriber, you may bill the client as you would a private patient. The client/subscriber's name can be turned over to a collection agency if necessary.

12. **What do I do when the subscriber (*other than* the MAA client) of the insurance policy receives payment and does not pay me?**

Bill the subscriber. Do not bill the client. Again, the subscriber's name can be turned over to a collection agency, if necessary.

Remittance and Status Report

Description of Remittance and Status Report

The Remittance and Status Report (RA) is the best tool you have to determine the status of your claim. RAs are generated weekly by the Medicaid Management Information System (MMIS) and accompanies MAA's payment to you for the services provided.

This report furnishes detailed information concerning any submitted claims as well as a summary of all transactions that have occurred during the previous week. Each line of the Remittance and Status Report represents all or part of a claim, and explains exactly what has happened to the claim. **MAA suggests that a provider retain their records for at least six years from the date of service, or longer if required by federal or state law or regulation (refer to WAC 388-502-0020).**

The Remittance and Status Report is available on magnetic tape.
Call Provider Enrollment at 1-800-562-6188 for information.

The following is a breakdown of the Remittance and Status Report:

1. **NEWSLETTER**: The *remittance newsletter* covers up to the first two pages of the Remittance and Status Report. *It is important to read this section each week!* Messages may concern rate changes, revised billing procedures, and many other items that may affect you ***immediately***. Please be sure this information is forwarded to your Medical Assistance billing staff or intermediary or to the management and clinical staff if received by the billing department or intermediary.

2. **PAID CLAIMS**: This section shows all claims paid during the previous week.

3. **DENIED CLAIMS:** This section shows claims denied during the previous week.

4. **CLAIMS IN PROCESS:** All claims entered into the MMIS, which have not reached final disposition, will appear in this area of the Remittance and Status Report. **This section is informational only!** Please do not take any action on claims displayed here. Do not rebill. *Remember!* The section is only showing you that MAA has begun processing and will continue processing until the claim is paid, denied, or returned. (It may take up to eight weeks for paper claim submission to appear in the *claims-in-process* section of the Remittance and Status Report.)

5. **CREDIT BALANCE CLAIMS:** These claims are considered *in process* and are held in suspense until a credit to MAA has been satisfied.

6. **ADJUSTMENTS: PAID CLAIMS**: These are adjustments to previously paid or denied claims where MAA has recouped the original payment and issued appropriate repayment.

7. **ADJUSTMENTS: DENIED CLAIMS**: These are adjustments to previously paid or denied claims where MAA has recouped the original payment and denied claims.

8. **ADJUSTMENTS: IN-PROCESS CLAIMS**: These are adjustments to previously paid or denied claims and claim has not reached final disposition.

9. **EOB MESSAGES:** Explanation of Benefits (EOB) codes are used to explain why your claim was paid or denied.

> ☞ **Note:** It is important to read these messages on paid claims, a well as on denied claims for information that may be necessary for future billings.

A Key To Your Remittance And Status Report

1. **Provider Name and Address:** Your business name and address as recorded with the MAA Division of Program Support (DPS) will be listed here.

2. **Provider Number:** The 7-digit billing (pay to) number assigned to you by DPS. Use this number with all correspondence and billings.

3. **RA Number:** This field is used to list the Remittance and Status (RA) Report number and your telephone number.

4. **Date:** This is the date the RA was issued.

5. **Page Number:** The page number of your RA.

6. **Patient ID:** Patient identification is indicated by:

   IN: First and middle initials (a dash (-) may be used if the middle initial is not known).
   DOB: Date of birth.
   TB: Tiebreaker - an alpha character automatically assigned
   NAME: Full last name.

7. **Patient Account Number:** Your *patient account number* will appear here if you entered one on your claim form. This is an alphanumeric field that you may use as your internal reference number. You may want to consider using this number to separate various accounts associated with your office (e.g., to separate different branch office accounts).

8. **Claim Number:** The Division of Program Support (DPS) assigns a 17-digit internal control number (ICN) to each claim received. Use this number when you have any questions concerning your claim. The Julian calendar is used to record the date your claims were received by DPS. The claim number represents the following information:

0	00	334	11	001	000100
A	B	C	D	E	F

   A — Claim Medium:

   - 0 = Hard copy claim
   - 1 = Direct entry/POS claim
   - 2 = Magnetic tape claim
   - 3 = Electronic media claim (e.g., floppy disk, personal computer)
   - 4 = State-system (MMIS) generated mass or gross adjustment

   B — Year of Claim Submission
   C — Julian Date
   D — Camera & Reel Number
   E — Batch Number
   F — Claim Number

9. **Service Date:** Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns.

10. **Day:** The number of days or units billed on your claim.

11. **Procedure/Revenue/NDC:** The procedure, revenue, DRG code, HCPCS, or NDC billed will appear in this column. If you used a modifier, it will also appear in this column.

12. **Total Charges:** The amount you billed.

13. **Total Allowed:** MAA's maximum allowable rate.

14. **Sales Tax:** Sales tax paid to you, if applicable.

15. **Other Deducted Charges:** Health or other insurance, client participation, Medicare payment amounts, etc., deducted from your payment.

16. **Payable Charges:** Amount payable to you. This amount is either:

    (a) the *total allowed*, *minus* other deducted charges, *plus* sales tax (if applicable);
    (b) the deductible and/or coinsurance amount; or
    (c) the hospital total allowed multiplied by the reimbursement rate.

17. **RR % (Reimbursement Rate):** For hospitals billing non-DRG claims, this is a percentage rate determined by MAA that is applied to the total allowed amount for the services.

18. **Paid Amount:** Total amount paid after applying all deductions, including the reimbursement rate (RR%), if applicable.

19. **EOB Codes.** A three-digit code which explains how and why the specific service was paid or denied. These codes and their meanings are listed at the end of your Remittance and Status Report. If your claim is being returned under separate cover, the message *RET* (*returned claim*) will appear here.

    The ***total check amount*** and ***year-to-date check amount*** appear at the end of your Remittance and Status Report. The ***total check amount*** reflects the amount of the enclosed warrant. The ***year-to-date-check*** amount reflects the total amount paid to you for the current calendar year.

***Note*:**

Warrants will not be issued if the final claims page on the Remittance and Status Report states, "PAID BY ELECTRONIC FUNDS TRANSFER TO ACCOUNT NO. XXXXXXXXX."

Warrants will not be issued for amounts less than $1.00. If the amount owed to you is less than $1.00, the claim will appear under the heading Credit Balance Claims.

WASHINGTON STATE DEPARTMENT OF SOCIAL & HEALTH SERVICES

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

PROVIDER NUMBER 2 RA NUMBER 3 DATE 4 PAGE 5

PATIENT ID 6				PATIENT ACCOUNT NUMBER	CLAIM NUMBER	SERVICE DATE		DAY	PROCEDURE/ REVENUE/ NDC	TOTAL CHARGES	TOTAL ALLOWED	SALES TAX	OTHER DEDUCTED CHARGES	PAYABLE CHARGES	RR %	PAID AMOUNT	EOB CODES
IN	DOB	TB	NAME			FROM MMDDYY	TO MMDDYY										
				7	8		9	10	11	12	13	14	15	16	17	18	19

WASHINGTON STATE DEPARTMENT OF SOCIAL & HEALTH SERVICES

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXX XX 99999-9999

PROVIDER NUMBER 9999999 RA NUMBER 999999 999 999-9999 DATE 05/15/00 PAGE 1

PATIENT ID IN	DOB	TB	NAME	PATIENT ACCOUNT NUMBER	CLAIM NUMBER	SERVICE DATE FROM MMDDYY	SERVICE DATE TO MMDDYY	DAY	PROCEDURE/ REVENUE/ NDC	TOTAL CHARGES	TOTAL ALLOWED	SALES TAX	OTHER DEDUCTED CHARGES	PAYABLE CHARGES	RR %	PAID AMOUNT	EOB CODES
PAID CLAIMS - CLAIM TYPE																	
XX	999999	X	XXXXXXXXXX		99999999999999999	011400	011400	1	99245	25100	11952	00	00	11952		11952	
XX	999999	X	XXXXXXXXXX	XXXX102100	99999999999999999	011300	011300	1	99213	6700	2674	00	00	2674		2674	
XX	999999	X	XXXXXXXXXX	XXXXI0210	99999999999999999	042800	042800	1	99212	4800	1932	00	00	1932		1932	
			PAID CLAIM TOTALS - CLAIM TYPE						3	36500	16558	00	00	16558		16558	
DENIED CLAIMS - PHYSICIAN CLAIM																	
XX	999999	X	XXXXXXXXXX		99999999999999999	011400	011400	1	99255	24400	00	00	00	00		00	212
			DENIED CLAIM TOTALS - CLAIM TYPE						1	24400	00	00	00	00		00	
CLAIMS-IN-PROCESS - CLAIM TYPE																	
XX	999999		XXXXXXXXXX	XXXX00100	99999999999999999	022100	022100	1	99213	6700	00	00	00	00		00	
			CLMS-IN-PROCESS TOTALS - CLAIM TYPE						1	6700	00	00	00	00		00	
ADJUSTMENTS PAID CLAIMS - CLAIM TYPE																	
XX	999999	X	XXXXXXXXXX	XXXXR00	99999999999999999	100599	100599	1	99223	21800-	9320-	00	00	9320-		9320-	CRE
						100699	100699	2	99231	11200-	00	00	00	00		00	CRE
						100899	100899	1	99238	11400-	4057-	00	00	4057-		4057-	CRE
					CLAIM TOTAL					44400-	13377-	00	00	13377-		13377-	CRE
XX	999999	X	XXXXXXXXXX	XXXXX00	99999999999999999	100599	100599	1	99223	21800	9320	00	00	9320		9320	
						100699	100799	2	99231	11200	4518	00	00	4518		4518	913
						100899	100899	1	99238	11400	4057	00	00	4057		4057	
					CLAIM TOTAL					44400	17895	00	00	17895		17895	
			ADJUSTMENTS PAID CLAIM TOTALS - CLAIM TYPE						2	00	4518	00	00	4518		4518	

-J.7-

WASHINGTON STATE DEPARTMENT OF SOCIAL & HEALTH SERVICES

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

XXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXX XX 99999-9999

PROVIDER NUMBER 9999999 RA NUMBER 999999 999 999-9999 DATE 05/15/00 PAGE 2

PATIENT ID IN	PATIENT ID COB	PATIENT ID TB	PATIENT ID NAME	PATIENT ACCOUNT NUMBER	CLAIM NUMBER	SERVICE DATE FROM MMDDYY	SERVICE DATE TO MMDDYY	DAY	PROCEDURE/ REVENUE/ NDC	TOTAL CHARGES	TOTAL ALLOWED	SALES TAX	OTHER DEDUCTED CHARGES	PAYABLE CHARGES	RR %	PAID AMOUNT	EOB CODES
									TOTAL CHECK AMOUNT							21078	
									YEAR-TO-DATE CHECK AMOUNT							172418	

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE:

212 PROCEDURE CODE IS NOT PAYABLE IN THIS PLACE OF SERVICE.

913 THIS IS AN ADJUSTMENT TO SERVICES PREVIOUSLY PAID OR DENIED.

Electronic Funds Transfer

Electronic funds transfer (EFT) for payment of medical claims and/or premiums is available to Medical Assistance Administration (MAA) providers.

How EFT works

With EFT, MAA deposits funds directly to your bank account each week that a payment is due. Funds are available on Tuesdays. If Monday is a holiday, funds will be available on Wednesday. This process does not affect the delivery of the Remittance and Status Reports that you currently receive with your payments. You will continue to receive these through the mail.

How to set up EFT

To receive payment through EFT, complete and return the attached authorization agreement. You may also fax the agreement to (360) 586-1209.

Three test transactions must be processed in order to verify that transmissions to your bank have been successful. During this time, MAA will mail checks directly to you.

If your account information changes, please contact the Provider Enrollment Unit immediately at 1-800-562-6188. Failure to do so may result in incorrect deposits or payment delays.

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Authorization Agreement for Electronic Funds Transfer (EFT)

Provider Name	**Medicaid Provider Number (Vendor ID)**
Address	**IRS/EIN Number**
City	**State Zip+4**
Contact Person Title	**Telephone Number**

I hereby authorize and request the Washington State Department of Social and Health Services (DSHS) to initiate credit entries to my [ ] checking [ ] savings account (select one) indicated below, and the depository named below is authorized to credit such account. If a reversal action is required, DSHS will notify the receiver of the error and give the reason for reversal. If any action taken by me, without adequate notification to DSHS, results in non-acceptance of the transfer by the designated financial institution, I understand that DSHS assumes no responsibility for processing supplemental payments until the funds are returned to DSHS by the financial institution.

Depository (Bank) Name	***Transit Routing Number**
	****Account Number**

***** **The transit routing number is the 9-digit target Bank Identification number assigned by the American Banking Association.**

****** **The account number is the provider's bank account number to which funds will be transferred.**

This authority will continue until DSHS has had a reasonable opportunity to act upon my written request to terminate EFT service or until DSHS determines that the required qualifications for enrollment are no longer being maintained.

Authorization (Print)	**Title (Print)**
Authorization Signature on Account	**Date**

PLEASE MAIL OR FAX FORM TO:

DSHS – Medical Assistance Administration
Division of Program Support
PO Box 45562
Olympia, WA 98504-5562
FAX: (360) 586-1209

Rebillings and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill, modify, or adjust a claim?

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service (see page H.2).

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

Rebillings

Rebill when:

- **The claim is denied in full**. When the entire claim is denied, check the Explanation of Benefits (EOB) code, then make the appropriate corrections (see below) and resubmit your claim on a regular billing form, not the adjustment form.

- **An individual line is denied on a multiple-line claim**. The denied service may be submitted as a rebill on a regular billing form, not an adjustment form.

- **The claim is returned under separate cover.** Occasionally, MAA is unable to process your claim and will return it to you with a letter stating what information is needed. Correct the information as directed and resubmit your claim.

How to Rebill

- Check any EOB code listed, then make your corrections on a copy of the claim OR produce a new claim with the correct information.

- Attach insurance information to the corrected claim, and send it to MAA.

  Note: Remember to line out or omit all lines that have already been paid on the claim before sending it back to MAA. Be sure to adjust the total.

  If you rebill the claim after the billing time limit has expired, or more than 365 days from the original date(s) of service on the claim, **enter the 17-digit claim number in field 22 (HCFA-1500) or in the claim area (UB92).** This claim number is proof of your timeliness. Providers have 36 months from the date of service to rebill their claims, except for prescription drug claims (see page H.2).

  Note: **If sixty (60) days (or more)** have elapsed since you sent your claim to MAA *and* it has not appeared on your Remittance and Status Report, resubmit your claim.

Adjustments

Adjust the claim only when:

- **The claim was paid, and an error was made** in procedure codes, diagnoses, units, or anything else that may affect payment. Send MAA an adjustment form indicating corrections.

- **The claim contained multiple surgical procedure codes, and one of the surgical procedures was denied or paid incorrectly.**

- **The claim was overpaid.** See how to adjust claims on next page.

- **The claim was paid but the information the provider sent is incorrect** and has affected payment.

What form do I use for adjustments?

All **adjustments** must be submitted on the **Adjustment Request form 525-109**. Use only *one* adjustment request form per claim. Submit multiple line corrections to a single claim on one adjustment request form. Adjustments are processed in two steps:

1. The MMIS will locate the claim you wish to adjust. The message *CRE* will appear in the EOB column on the MAA Remittance and Status Report.

2. The action requested will be completed, and the claim will be processed accordingly. (Requesting an adjustment does not necessarily mean that your claim will be paid.) The adjusted claim may be denied again if the original disposition was correct or if the information provided on the Adjustment Request is incorrect or incomplete.

Be sure that proper documentation is attached to your adjustment request (operative reports, Remittance and Status Reports, etc.) to avoid another denial or incorrect disposition of your claim.

How To Adjust Overpayments

- Submit an adjustment: MAA will recoup your claim and deduct the excess amount from your future remittance check(s) until the overpayment is satisfied; **OR**

- Issue a refund check payable to DSHS: Attach a copy of the Remittance and Status Report showing the paid claim and include a brief explanation for the refund (e.g., insurance payment, duplicate payment).

  Mail this to:

Finance Division
PO Box 9501
Olympia WA 98507-9501

Submit an adjustment –OR- refund by check.
Do not adjust and refund for the same claim.

How to Complete the Adjustment Request Form (525-109)

Use the Adjustment Request form 525-109 (Rev. 11/91) for all correction requests. The numbered blocks on the form are referred to as *fields*. Complete the fields as explained below, using the exact information from your Remittance and Status Report.

FIELD # DESCRIPTION

1. **Type of Claim**: Check the type of claim originally submitted for payment.

2. **Claim Number to be Adjusted**: **Required**. Enter the 17-digit number from the claim you wish to correct. Submit only one adjustment request per claim number. You must complete this field or your adjustment request will be denied.

3. **Provider Number**: **Required.** Enter your assigned provider billing number as shown on the Remittance and Status Report. You must complete this field or your adjustment request will be denied.

4. **Patient ID from Remittance and Status Report (RA)**: **Required**. You must complete this field or your adjustment request will be denied.

5. **Date(s) of Services: Required.** Enter beginning and ending dates of service for the *entire* claim, not just the line item you wish to adjust. You must complete this field or your adjustment request will be denied.

6. **Patient's Name**: Enter the client's last name, first name, and middle initial.

7. **RA Date**: **Required.** You must enter the date of the Remittance and Status Report (shown in the upper right corner).

EOB(s) on RA: Enter the EOB code on the Remittance and Status Report explaining the reason for denial, cutback, etc. *Note: If there is no code, leave this field blank.*

8. **Date of Request**: Enter today's date.

9. **Corrected Patient ID**: Use this area if a service has been paid under the wrong patient's ID code *or* if a service was previously billed for a baby under a parent's PIC and you now have a PIC for the baby.

If a claim has been denied with "not eligible" or "not eligible for date of service," **do not rebill on an adjustment form.** Use a regular billing form.

10. **Items to be Corrected**: Locate the category needing correction *(A through K)*.

Information on RA/Claim: Enter *incorrect* information as it appears on the Remittance and Status Report or on the original claim.

Corrected Information: Enter the *corrected* data.

NOTE: You should *only* complete the spaces for those items you wish to correct.

11. Other Remarks/Justification/Award Letters/Approvals

This space is for any additional information pertaining to the reason for the adjustment. Attach a copy of the award letter, a copy of the MAID card, or approval, if necessary, for MAA to properly process the adjustment. (When attaching copies, **do not staple in the bar area**.)

12. Third-Party Liability Information/Payment/Denial: If a claim was paid or denied by other insurance sources, attach a copy of the EOB from the insurance company *and* the Remittance and Status Report.

13. For DSHS Use

14. Provider Name and Address: Enter your phone number. Enter your name and address as shown on the Remittance and Status Report.

DO NOT STAPLE IN BAR AREA

[redacted]

ADJUSTMENT REQUEST

ICN – DSHS USE ONLY

* THE CIRCLED NUMBERS INDICATE BLOCKS WHICH MUST BE COMPLETED FOR YOUR CLAIM TO BE PROCESSED.

USE BLACK INK, PRESS HARD

ENTER DATA FROM REMITTANCE REPORT

* (1) TYPE OF CLAIM (CHECK ONE)

- ☐ Physician / HCFA 1500
- ☐ Medical Vendor / HCFA 1500
- ☐ EPSDT / HCFA 1500
- ☐ Dental / 525-108
- ☐ Pharmacy / 525-106
- ☐ Nursing Home / TAD
- ☐ DRG / UB-82
- ☐ Outpatient / UB-82
- ☐ Inpatient / UB-82
- ☐ Medicare IP-OP / UB-82
- ☐ Medicare Physician / 525-107

* (2) CLAIM NUMBER TO BE ADJUSTED: 0[redacted]9|9|0|1|6[redacted]1|2[redacted]0|0|6[redacted]0|0|1|8|0|0

(3) PROVIDER NUMBER: 7654321

(4) PATIENT I.D. FROM REMITTANCE REPORT: J|R[redacted]0|1|0|6|6|2[redacted]J|O|N|E|S[redacted]A

* (5) DATE(S) OF SERVICE (ENTIRE CLAIM) FROM: 2/12/99 TO: 2/12/99

(6) PATIENT'S LAST NAME, FIRST, M.I.: Jones, Joan R.

7. R.R. DATE	EOB(S) ON R.R.	8. DATE OF REQUEST	9. CORRECTED PATIENT I.D.
3/11/99			[redacted]

10. ITEMS TO BE CORRECTED (MORE THAN ONE ITEM PER CLAIM NUMBER CAN BE ADDRESSED, HOWEVER NO MORE THAN ONE CLAIM PER ADJUSTMENT)	INFORMATION ON R.R. / CLAIM	CORRECTED INFORMATION
A. BILLED AMOUNT		
B. PROCEDURE DESCRIPTION		
C. DRUG NAME		
D. REVENUE CODES		
E. DATE OF SERVICE / DAYS		
F. PLACE / TYPE OF SERVICE		
G. QUANTITY / UNITS		
H. DIAGNOSIS		
I. TOOTH / SURFACE / ARCH		
J. PATIENT CLASS / STATUS		
K. PROCEDURE CODE / NDC		

11. OTHER REMARKS / JUSTIFICATION / AWARD LETTERS / APPROVALS (ATTACH COPY):

Example: Erroneous Procedure Code Reported.
Note: Please refer to your General Information Booklet for instructions on completing this adjustment request

DSHS USE ONLY

12. THIRD PARTY LIABILITY INFORMATION / PAYMENT / DENIAL.
- A. ATTACH INSURANCE EOB DENIAL / PAYMENT
- B. NAME OF INSURANCE
- C. AMOUNT PAID BY INSURANCE $
- D. BALANCE OWING $

13. ☐ THIS IS BEING RETURNED TO YOU SO THE REQUIRED BLOCK(S) CAN BE COMPLETED. SEE BILLING INSTRUCTIONS. ☐ OTHER, SEE ATTACHED

* (14) PROVIDER PHONE # (360) 999-1111

PROVIDER NAME AND ADDRESS

Community Clinic
12 Main Street
Anytown, WA 98000

MAIL TO: DIVISION OF PROGRAM SUPPORT
PO BOX 9245
OLYMPIA WA 98504

525-109 (6-85)

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

STATE COPY

DSHS USE ONLY

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

COMMUNITY SERVICES DIVISION (2/3/00)

50 CSOs - 12 Branch Offices - 3 Outstation's

Names - Addresses	CSO #	Mail Stop	Phone & Fax #
MEDICAL ELIGIBILITY DETERMINATION *(Children's Medical, Healthy Options, Basic Health Plus)* 1011 Plum Street, Bldg 5, 4th Floor MS: 45531 Olympia WA 98504-5531	**76**	**45531**	1-800-204-6429
REGION 1			
GRANT/ADAMS CSO (MOSES LAKE) 1620 South Pioneer Way Moses Lake, WA 98837	**13**	**B13-2**	509-764-5600 509-764-5747 Fax
OTHELLO CSO 1025 South First Street/PO Box 711 Othello, WA 99344	**01**	**B01-2**	509-488-9673 509-488-5068 Fax
OKANOGAN CSO 130 South Main/PO Box 3729 Omak, WA 98841	**24**	**B24-1**	509-826-7200 509-826-7293 Fax
SPOKANE CENTRAL CSO 1313 North Maple Street Spokane, WA 99201-2749	**32**	**B32-3**	509-227-2500 509-456-2461 Fax
COLFAX BRANCH OFFICE 418 South Main, Suite 1 Colfax, WA 99111	**38**	**B38-1**	509-397-4326 509-397-3498 Fax
SPOKANE EAST CSO 121 South Arthur/PO Box 2640 Spokane, WA 99202-2640	**58**	**B58-1**	509-533-2326 509-533-2343 Fax

Names - Addresses	CSO #	Mail Stop	Phone & Fax #
SPOKANE NORTH CSO 1925 East Francis Spokane, WA 99207-3747	**59**	**B59-1**	509-227-2200 509-483-5716 Fax
SPOKANE SOUTHWEST CSO 1313 North Maple Spokane, WA 99201	**60**	**B60-1**	509-227-2400 509-456-3093 Fax
DAVENPORT BRANCH OFFICE 506 8th Street/PO Box 640 Davenport, WA 99122	**22**	**B22-1**	509-735-5009 509-725-2056 Fax
TRI-COUNTY/COLVILLE CSO 1100 South Main, Suite 1 Colville, WA 99114	**33**	**B33-1**	509-685-5600 509-685-5606 Fax
NEWPORT BRANCH OFFICE 1600 West 1st Street/PO Box 570 Newport, WA 99156-0570	**26**	**B26-1**	509-447-3192 509-447-4732 Fax
REPUBLIC OUTSTATION 147 North Clark Avenue/PO Box 1037 Republic, WA 99166	**10**	**B10-1**	509-775-3155 509-775-2401 Fax
WENATCHEE CSO 805 South Mission/PO Box 3088 Wenatchee, WA 98807	**04**	**B4-1**	509-662-0511 509-664-6340 Fax
CLARKSTON CSO 525 Fifth Street Clarkston, WA 99403	**02**	**B2-1**	509-751-4600 509-758-4582 Fax

Names - Addresses	CSO #	Mail Stop	Phone & Fax #
REGION 2			
GRANDVIEW CSO 1313 West Wine Country Road/PO Box 70 Grandview, WA 98930-0070	**70**	**B70-1**	509-882-9300 509-882-4589 Fax
KENNEWICK CSO 1120 North Edison Street/PO Box 6330 Kennewick, WA 99336	**03**	**B03-4**	509-735-7119 509-736-2857 Fax
PASCO CSO 800 West Court/PO Box 931 Pasco, WA 99301	**11**	**B11-1**	509-545-1400 509-546-2414 Fax
SUNNYSIDE CSO 810 East Custer Avenue/PO Box 818 Sunnyside, WA 98944	**54**	**B54-1**	509-839-7200 509-839-7224 Fax
TOPPENISH CSO 306 Bolin Drive/PO Box 470 Toppenish, WA 98948	**50**	**B50-1**	509-865-2805 509-865-1133 Fax
WALLA WALLA CSO 416 East Main/PO Box 517 Walla Walla, WA 99362	**36**	**B36-1**	509-529-0406 509-522-4330 Fax
WAPATO CSO 102 North Wapato Avenue/PO Box 66 Wapato, WA 98951	**75**	**B75-1**	509-877-8122 509-877-8149 Fax
YAKIMA CSO 1002 North 16th Avenue/PO Box 12500 Yakima, WA 98909-2500	**39**	**B39-1**	509-225-6100 509-454-4332 Fax

Names - Addresses	CSO #	Mail Stop	Phone & Fax #
YAKIMA/KITTITAS CSO 1002 North 16th Avenue/PO Box 12500 Yakima, WA 98909	**69**	**B69-1**	509-225-6210 509-575-2088 Fax
ELLENSBURG BRANCH OFFICE 521 Mountain View/PO Box 366 Ellensburg, WA 98926	**19**	**B19-1**	509-962-7710 509-962-7736 Fax
REGION 3			
ALDERWOOD CSO 20311 52nd Avenue West/PO Box 97012 Lynnwood, WA 98046-9712	**52**	**N52-1**	425-673-3000 425-672-2295 Fax
BELLINGHAM CSO 4101 Meridian Street/PO Box 9706 Bellingham, WA 98227-9706	**37**	**B37-1**	360-714-4000 360-714-4066 Fax
EVERETT CSO 840 North Broadway, Suite 200 Everett, WA 98201-1297	**31**	**N31-1**	425-339-4000 425-339-4890 Fax
MOUNT VERNON CSO 900 East College Way; Suite 100 Mount Vernon, WA 98273-5682	**29**	**B29-1**	360-416-7444 360-416-7279 Fax
FRIDAY HARBOR OUTSTATION 55 Second Street, Suite 101/PO Box 1215 Friday Harbor, WA 98250	**28**	**B29-10**	360-378-4196 CSOA 360-378-4098 Fax
OAK HARBOR CSO 656 Southeast Bayshore Drive #1 Oak Harbor, WA 98277	**15**	**B15-1**	360-240-4700 360-679-3524 Fax
SKYKOMISH VALLEY CSO 19705 SR 2/PO Box 7000 Monroe, WA 98272	**68**	**B68-1**	360-794-1350 360-794-1360 Fax

Names - Addresses	CSO #	Mail Stop	Phone & Fax #
SMOKEY POINT CSO 3704 172nd Street NE, Suite P/PO Box 3099 Arlington, WA 98223-3099	**65**	**B65-1**	360-658-2200 360-658-2294 Fax
REGION 4			
BALLARD CSO 907 Northwest Ballard Way Seattle, WA 98107-4683	**42**	**N42-1**	206-789-5200 206-706-4252 Fax
BELLTOWN CSO 2106 - 2nd Avenue Seattle, WA 98121-2298	**47**	**N47-1**	206-956-3353 206-956-3360 Fax
BURIEN CSO 15811 Ambaum Boulevard Southwest Seattle, WA 98166-3090	**44**	**N44-1**	206-439-5300 206-439-5324 Fax
CAPITOL HILL CSO 1700 East Cherry Seattle, WA 98122-4694	**46**	**N46-1**	206-568-5500 206-720-3189 Fax
FEDERAL WAY CSO 616 South 348th/PO Box 4629 Federal Way, WA 98063-4629	**45**	**N45-1**	253-835-2800 253-661-4925 Fax
KING EASTSIDE CSO 14360 Southeast Eastgate Way Bellevue, WA 98008-0429	**40**	**N40-1**	425-649-4000 425-649-4058 Fax
KING SOUTH CSO PO Box 848 Kent, WA 98032-0848	**43**	**N43-1**	253-872-2145 253-872-2735 Fax

Names - Addresses	CSO #	Mail Stop	Phone & Fax #
LAKE CITY CSO 11536 Lake City Way Northeast Seattle, WA 98125-5395	**74**	**N74-1**	206-368-7200 206-368-7189 Fax
RAINIER CSO 3600 South Graham Seattle, WA 98118-3034	**41**	**N41-1**	206-760-2000 206-760-2345 Fax
RENTON CSO 500 Southwest 7th Street, Suite B Renton, WA 98055	**80**	**N80-1**	425-793-5700 425-277-7289 Fax
WEST SEATTLE CSO 4045 Delridge Way SW, Suite #300 Seattle, WA 98106	**55**	**N55-1**	206-933-3300 206-933-3315 Fax
REGION 5			
BREMERTON CSO 4710 Auto Center Boulevard Bremerton, WA 98312-3300	**18**	**W18-1**	360-478-4995 360-478-6960 Fax
PIERCE NORTH CSO 1949 South State Street, 2nd Floor Tacoma, WA 98405-9945	**49**	**N49-1**	253-593-2950 253-597-4319 Fax
PIERCE SOUTH CSO 1301 East 72nd Tacoma, WA 98404-3348	**48**	**N48-1**	253-471-4400 253-471-4411 Fax
PIERCE WEST CSO 1949 South State Street, 1st Floor Tacoma, WA 98405-9943	**67**	**N67-1**	253-593-2760 253-593-2313 Fax
PUYALLUP VALLEY CSO 1004 East Main Puyallup, WA 98372-9987	**51**	**N51-1**	253-840-4600 253-840-4715 Fax

Names - Addresses	CSO #	Mail Stop	Phone & Fax #
REGION 6			
ABERDEEN CSO 415 West Wishkah/PO Box 189 Aberdeen, WA 98520	**14**	**W14-1**	360-537-2600 360-533-9445 Fax
ELMA BRANCH OFFICE 575 East Main, Suite A/PO Box 799 Elma, WA 98541	**61**	**W61-1**	360-482-8900 360-482-2850 Fax
SOUTH BEND BRANCH OFFICE 307 E. Robert Bush Drive/PO Box 87 South Bend, WA 98584	**25**	**W25-1**	360-875-6501 360-875-0590 Fax
LONG BEACH BRANCH OFFICE 603 South Oregon/PO Box 429 Long Beach, WA 98631	**71**	**B71-1**	360-642-3791 360-642-6229 Fax
CHEHALIS CSO 2025 Northeast Kresky Road/PO Box 359 Chehalis, WA 98532	**21**	**S21-1**	360-740-3800 360-748-2286 Fax
KELSO CSO 711 Vine/PO Box 330 Kelso, WA 98626-0026	**08**	**S8-1**	360-501-2400 360-577-2296 Fax
OLYMPIA CSO 5000 Capitol Boulevard/PO Box 1908 Olympia, WA 98507-1908	**34**	**45455**	360-753-5983 360-586-6787 Fax
ORCHARDS CSO 11900 NE 95th Street, Bldg 4/P.O. Box 4485 Vancouver, WA 98662	**53**	**S53-1**	360-260-6400 360-260-6423 Fax
GOLDENDALE BRANCH OFFICE 808 South Columbus/PO Box 185 Goldendale, WA 98620	**62**	**B62-1**	509-773-5835 509-773-4282 Fax

Names - Addresses	CSO #	Mail Stop	Phone & Fax #
STEVENSON BRANCH OFFICE 266 SW Second Street/PO Box 817 Stevenson, WA 98648	**30**	**B30-1**	509-427-5611 509-427-4604 Fax
WHITE SALMON BRANCH OFFICE 221 North Main/PO Box 129 White Salmon, WA 98672	**20**	**B20-1**	509-493-1012 CSOA 509-493-1882 Fax
PORT ANGELES CSO 201 West First Street/PO Box 2259 Port Angeles, WA 98362	**05**	**B5-1**	360-565-2180 360-417-1461 Fax
NEAH BAY OUTSTATION Bayview Avenue Community Building PO Box 153 Neah Bay, WA 98357	**05**	**B64-2**	360-645-2452 Fax
PORT TOWNSEND BRANCH OFFICE 623 Sheridan/PO Box 554 Port Townsend, WA 98368	**16**	**B16-1**	360-379-4300 360-379-5017 Fax
FORKS BRANCH OFFICE 421 5th Avenue Southwest Forks, WA 98331	**64**	**B64-1**	360-374-2257 360-374-5464 Fax
SHELTON CSO 2505 Olympic Hwy N, Suite 440/PO Box 1127 Shelton, WA 98584-0937	**23**	**W23-1**	360-432-2000 360-427-2010 Fax
VANCOUVER CSO 907 Harney Street/PO Box 751 Vancouver, WA 98666	**06**	**S6-1**	360-993-7700 360-696-6406 Fax

April 1999

HOME & COMMUNITY SERVICES DIVISION HEADQUARTERS, REGIONAL & HCS DIRECTORY OFFICES				
Names – Addresses	**HCS #**	**Mail Stop/ County**	**Phone**	**Fax**
HEADQUARTERS Home & Community Services Division (HCS) 600 Woodland Square Loop SE Lacey, WA 98503		45600	(360) 493-2542 (360) 493-9251	(360) 438-8633
REGION 1 1427 West Gardner Spokane, WA 99201-1935		B 32-27	(509) 323-9400 1-800-459-0421	(509) 458-3558
Spokane HCS 1427 West Gardner Spokane, WA 99201-1935	57	B 32-27 Spokane Co.	(509) 323-9400 1-800-459-0421	(509) 458-3558
Colville HCS 1100 S. Main St. Colville, WA 99114-9545	78	B 33-05 Stevens Co.	(509) 685-5644 1-800-459-0421	(509) 684-7430
Moses Lake HCS 1620 So Pioneer Way Moses Lake, WA 98837-0301	81	B 13-04 Grant Co.	(509) 764-5657 1-800-671-8902	(509) 764-5656
Omak (Okanogan) HCS 130 S. Main Omak, WA 98841-3729	77	B 24-03 Okanogan Co.	(509) 826-7232 1-800-459-0421	(509) 826-7439
Wenatchee HCS 805 South Mission Wenatchee, WA 98801-3053	79	B 04-04 Douglas Co.	(509) 662-0559 1-800-670-8874	(509) 665-3312
REGION 2 PO Box 9817 (98909-9817) 1002 N 16th Avenue Yakima, WA 98902		B 39-14	(509) 575-2006 1-800-822-2097	(509) 575-2286
Yakima HCS PO Box 9817 (98909-9817) 1002 N 16th Avenue Yakima, WA 98902	82	B 39-14 Yakima Co.	(509) 575-2006 1-800-822-2097	(509) 575-2286
*** Ellensburg-Yakima Branch Office** PO Box 366 521 E. Mountain View Ellensburg, WA 98926-0366	82*	B 19-03 Kittitas Co.	(509) 962-7760 1-800-310-4999	(509) 962-7736

Names – Addresses	HCS #	Mail Stop/ County	Phone	Fax
Sunnyside HCS PO Box 818 2010 Yakima Valley Hwy/K15 Sunnyside, WA 98944-0818	83	B 54-04 Yakima Co.	(509) 839-7278 1-800-310-5923	(509) 839-6990
***Toppenish-Sunnyside Branch Office** PO Box 470 (98948-0470) 306 Bolin Drive Toppenish, WA 98948-1644	83*	B 50-03 Yakima Co.	(509) 865-1127	(509) 865-2028
Pasco HCS PO Box 931 800 W Court Pasco, WA 99301-0931	84	B 11-07 Franklin Co.	(509) 545-2625 1-800-310-4833	(509) 545-2617
Walla Walla HCS 206 West Poplar Walla Walla, WA 99362-0219	85	B 36-04 Walla Walla Co.	(509) 527-4614 1-800-310-5678	(509) 527-4142
Clarkston HCS 525 Fifth Street Clarkston, WA 99403-2090	86	B 2-4 Asotin Co.	(509) 758-4562 (509) 758-4516 1-800-310-4881	(509) 758-4593
REGION 3 900 East College Way Suite 210 Mt. Vernon, WA 98273-5688		B 29-03	(360) 416-7289 1-800-487-0416	(360) 416-7401
Mt. Vernon HCS 900 East College Way, Suite 210 Mt. Vernon, WA 98273-5688	63	B 29-03 Skagit Co.	(360) 416-7289 1-800-487-0416	(360) 416-7401
Alderwood HCS 19009 33rd Avenue West, Suite 306 Lynnwood, WA 98036-4710	89	N 52-03 Snohomish Co.	(425) 672-2855 1-800-780-7089	(425) 672-3178
Bellingham HCS 600 Lakeway Drive Bellingham, WA 98225-5236	87	B 37-08 Whatcom Co.	(360) 738-6200 1-800-239-8292	(360) 676-2239
Everett HCS 840 N. Broadway, Suite 330 Everett, WA 98201-1262	92	N 31-08 Snohomish Co.	(425) 339-4010 1-800-780-7094	(425) 339-1885
Skykomish Valley HCS PO Box 7000 19705 SR #2 (no street delivery) Monroe, WA 98272-9902	90	B 68-03 Snohomish Co.	(360) 805-8895 1-800-398-4172	(360) 805-8569

Names – Addresses	HCS #	Mail Stop/ County	Phone	Fax
Smokey Point HCS PO Box 3504 3310 Smokey Point Drive Arlington, WA 98223-3504	91	B 65-03 Snohomish Co.	(360) 653-0584 1-800-827-2984	(360) 653-0569
REGION 4 PO Box 24847 1737 Airport Way S., Suite 130 Seattle, WA 98124-0847		N 95-02	(206) 341-7750 1-800-346-9257	(206) 464-6991
Holgate HCS PO Box 24847 Seattle, WA 98124-0847 1737 Airport Way S Suite 130 Seattle, WA 98124-6407	56	N 95-02 King Co.	(206) 587-4440 1-800-346-9257	(206) 464-6689
REGION 5 1949 South State Street Tacoma, WA 98405-2850		N 66-02	(253) 597-3600 1-800-442-5129	(253) 597-4296
Tacoma HCS 1949 South State Street Tacoma, WA 98405-2850	66	N 66-02 Pierce Co.	(253) 597-3600 1-800-442-5129	(253) 597-4296
Bremerton HCS 4710 Kean Street Bremerton, WA 98312-4397	88	W 18-07 Kitsap Co.	(360) 478-4990 1-800-422-7114	(360) 478-6467
***Puyallup HCS – Tacoma Branch** 1011 E. Main Street, Suite 101 Puyallup, WA 98372	66*	N 51-2 Pierce Co.	(253) 840-4550 1-800-804-1327	(253) 840-4726
REGION 6 P.O. Box 45610 (98504-5610) 6737 Capitol Blvd. S., 1st Floor Tumwater, WA 98501		45610	(360) 664-7575 1-800-462-4957	(360) 664-7603
Tumwater HCS PO Box 45610 (98504-5610) 6737 Capitol Blvd. S., 1st Floor Tumwater, WA 98501	96	45610 Thurston Co.	(360) 664-7575 1-800-462-4957	(360) 664-7603
Aberdeen HCS PO Box 85 503 West Heron St. Aberdeen, WA 98520	94	W 14-05 Grays Harbor Co.	(360) 533-9218 1-800-487-0119	(360) 533-9729
Chehalis HCS PO Box 1186 500 SE Washington Ave., 3rd Flr. Chehalis, WA 98532	95	S 21-04 Lewis Co.	(360) 740-6572 1-800-487-0360	(360) 740-6585

Names – Addresses	HCS #	Mail Stop/ County	Phone	Fax
Kelso HCS 711 Vine Street Kelso, WA 98626-2621	97	S 8-07 Cowlitz Co.	(360) 577-5424 1-800-605-7322	(360) 578-4106
Port Angeles HCS PO Box 2289 228 West 1st Street, Suite 0 Port Angeles, WA 98362	93	B 5-03 Clallam Co.	(360) 417-1423 1-800-280-9891	(360) 417-1416
Vancouver HCS 5411 E Mill Plain Blvd., Suite 25 Vancouver, WA 98661-7046	98	S 53-04 Clark Co.	(360) 992-7945 1-800-280-0586	(360) 992-7949
*** HCS branch offices share the same HCS office number.**				
HCS offices not co-located with CSOs:	**Spokane, Walla Walla, Alderwood, Bellingham, Smokey Point, Holgate, Puyallup, Tumwater, Vancouver, Pt. Angeles, Aberdeen, Chehalis**			